

A Caring Society

Liberal Democrat Proposals to Improve the Organisation of Social Services



Policy Paper 1

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A Caring Society: Summary

This paper is about putting individuals in charge of their own lives. It is about enabling everyone to live their lives to the full and to make the most of their abilities.

This means providing a just and realistic social security system, adequate housing and health care, and improved social, educational and employment opportunities. It means a Bill of Rights to outlaw discrimination, investment in training and education, and improvements to the basic state pension, disability benefits and benefits for carers. For some people such provisions would mean an end to their reliance on social services.

We recognise, however, that whatever other improvements are made, some people will continue to be reliant upon social services: young people at risk, vulnerable elderly people, people with disabilities, people with mental health problems and others. In all the proposals which we make we have sought to *put people first*. We aim:

- To *encourage independent living* wherever practicable, supported by mobile services wherever necessary.
- To *facilitate informed choice* for both users and carers.
- To *enhance the development of communities* to give real substance to the slogan 'care in the community'.

These objectives require open and accessible planning processes; information about the range and availability of services and the process of decision-making; and high standards and inspection to maintain those standards.

As a first step to creating a more coherent planning structure, *we would abolish the largely artificial distinction between health and social care*. Definitions differ widely from area to area and the distinction often leads to confusion as to where the responsibility for service delivery should lie and who should pay for the services.

Our objective is to create *a single 'seamless service' of health and social care provision*. We propose to integrate fully all health and social services. We would:

- *Merge district health authorities and local authority social service departments* into single departments within democratically elected local authorities to plan and purchase the whole range of health and social provision.
- *Transform regional health authorities into democratic regional health and social services departments* under the auspices of regional governments, as and when these are established.

- *Incorporate both health and social care provision into community care plans.*
- *Abolish the distinction between nursing and residential homes and establish a single registering body for care homes within each local authority.*

High quality community care provision is expensive. Local people must have a say in determining spending priorities. *Liberal Democrats would therefore bring all health and social care planning under direct local democratic control.* We would extend the powers of Community Health Councils to include social services, and involve users and their representatives in decisions over the allocation of resources and planning of services.

For Liberal Democrats the funding of community care is a high priority. We reject the Conservative Government's attempts to treat 'care in the community' as a cost-cutting exercise. While they continue to underfund local government and to 'cap' expenditure, *we believe that there may be a case for ring fencing community care budgets.* The paper presents options both for and against ring fencing in the short term.

National government must take responsibility for ensuring high standards in community care. It must play the key role in inspection and enforcement. We would extend the role of the current Social Services Inspectorate to include health, make it independent of government, and enhance its powers to enforce standards in training, environmental protection and health and safety.

The Liberal Democrats' people-centred approach concentrates on the development of individual assessment and funding for service users, advocacy and rights to information and consultation. *Our aim is to put the service user in charge.*

Liberal Democrats further believe that the quality of life of the carer is just as important as that of the person for whom care is being provided. We would:

- Introduce an enhanced Carers' Benefit for unpaid carers.
- Increase training for all those involved in providing care, whether paid or unpaid.
- Extend the provision of respite care and guarantee the right of carers to have their care needs assessed separately.

Liberal Democrats are committed to creating a properly funded programme of care in the community, centred on individual users and carers, and fully integrated with health care provision.

Our objective can be simply summarised: to enable all Britain's citizens to live their lives with dignity and self-respect.

Where We Start

1.0.1 In February 1991, the Liberal Democrats published our first policy paper on community care. It was called *Agenda for Caring*. This adopted a ‘people first’ approach, centring on meeting the needs and aspirations of individual service users. We recommended:

- That local authorities be given responsibility for coordinating, planning and funding community care.
- That users be given greater control over services and a wider range of care options through the development of advocacy and self-advocacy schemes.
- Greater recognition of the rights of carers, including adequate financial support and the development of wider support networks.
- Increased resources for community care, with resources allocated on the basis of individuals’ needs, not the form of care they receive.
- The development of a wide range of specialist housing and residential accommodation.
- An enhanced role for the voluntary sector, to act both as advocates as well as service providers.

1.0.2 *Agenda for Caring* was written in the light of the 1988 report by Sir Roy Griffiths, *Community Care: An Agenda for Action*. The Liberal Democrat policy endorsed Griffiths’ general approach: to create a user-led service, based on an assessment of individuals’ needs. He recommended that the service be coordinated by local authorities and adequately grant-funded by central government.

1.0.3 The Griffiths Report reaffirmed the trend of the previous two decades, away from

large scale institutionalised care towards ‘care in the community’, a system based on independent living supported by mobile services. For example, 25 years ago almost 60,000 people lived in long stay, large scale specialist ‘mental handicap’ (sic.) hospitals. Now that figure is nearer 19,000. The closure of such hospitals is to be welcomed, but Griffiths clearly identified the need to plan strategically for their replacement. Care planners now have an opportunity to be more creative in their care provision and to reexamine the nature of care. Small scale residential homes, care at home and independent living schemes are all part of the programme of care in the community envisaged by Griffiths and supported by the Liberal Democrats.

***A ‘people first’ approach,
centring on meeting the needs and
aspirations of individuals.***

1.0.4 The Government’s response to the Griffiths Report was not favourable. It took over 15 months for it to publish a white paper, *Caring for People*, in response to Griffiths. It then took a further year for the 1990 NHS and Community Care Act to become law. Even then, the Act contained none of the clarity of thought of the original report. It failed to guarantee that local authorities would receive the resources recommended by both Griffiths and the Liberal Democrats, or to establish clear ministerial responsibility for community care provision. The relationship between local authorities and health authorities was ill-defined and ad hoc, leading in some cases not to care, but to chaos, in the community.

1.0.5 Labour's response to the Act has been incomprehensible, at one moment declaring it to be "*Thatcherism's last hurrah, a doomed attempt to impose the discredited dogma of privatisation on services to disabled people*" (Robin Cook, 11.89), and at the next complaining that "*Parliament has never been given a reason for the decision to delay implementation of the Community Care Act... Change needs to be quick and effective*" (*Better Community Care*, Labour document 2.92).

1.0.6 Liberal Democrats have taken a more constructive approach. For all its faults, the developments within the Act represent a significant advance on the days of large, faceless institutions tucked tastefully out of the sight. Liberal Democrats, therefore, supported the Government's proposals for community care as they then stood, despite some reservations.

1.0.7 No sooner had the Act been passed, however, than the Government announced that the implementation of its key proposal - namely, the transfer to local authorities of social security budgets for independent residential care - would be delayed until April 1993. As this date drew near, the Government's desire to use the transfer to cut public expenditure rather than raise standards became increasingly transparent. When the grants for the first year's transfer were announced, they fell significantly short of the amount which local authorities considered necessary for the successful implementation of the programme.

1.0.8 It is still too early to foretell the impact of the April 1993 reforms, although the first signs are not good. Despite the long delay in implementation, many local authorities appear to be ill-prepared to take on their responsibilities. Some local authorities appear to have opted to provide the minimum service possible, while in others community care plans seem scant and uninformed. Dialogue with District Health Authorities and Family Health Service Authorities has often been erratic and

unproductive. Conversely, those local authorities that have taken their new responsibilities seriously have found themselves frustrated by the strictures of inadequate funding. Concern that community care will suffer further at the hands of the Treasury's public expenditure review has led some professionals to despair.

1.0.9 In such an environment, another centrally-imposed overhaul of community care, based on entirely different principles, would not be welcomed by users, carers or professionals. And anyway, the Government's approach contains many elements which could be effective:

- *More say for individuals*, both users and carers.
- *Greater local democratic control*.
- *A mixed-market of providers*, from the public, private and voluntary sectors.

1.0.10 It is our intention, therefore, in reviewing and updating *Agenda for Caring*, to build on the strengths and eliminate the weaknesses of the current system, rather than to rip up the blueprint and start again. Yet, if the new proposals are to be made to work as Griffiths intended them, then there are three steps which we would take immediately on coming to power:

- *First*, a clear commitment must be given to funding community care properly. 'Care in the Community' must not become a mechanism for cutting costs or cutting corners. National government must not negate its responsibility for community care.
- *Second*, local authorities must look to their community care plans to ensure that the mixed market of provision envisaged does help to meet individual needs.
- *Third*, the relative responsibilities of social services and health authorities must be more clearly defined.

The Liberal Democrat Approach

2.0.1 Liberal Democrats believe in a community of individuals with rights and responsibilities; one in which all are active contributors to the well-being of society as a whole, each according to his or her own strengths and abilities.

2.0.2 Accordingly, we believe that care packages should be designed to:

- *Encourage independent living* wherever practicable, supported by mobile services, where necessary.
- *Facilitate informed choice* for both users and carers.
- *Enhance the development of communities* to give real meaning to the slogan ‘Care in the Community’.

2.0.3 This principle has implications for our priorities in providing care. Liberal Democrat priorities would promote informed choice for service users through:

- *A process of planning which is open and accessible*, particularly to service users.
- *Information* about the range of available services and the process of decision making affecting users’ lives.
- *High standards, and inspection* to maintain those standards.
- *Advocacy* to give the user access to independent advice in the construction of care plans.
- *A means of holding decision-makers to account.*

2.0.4 These priorities lead us to support the principle of separating the assessment, planning

and purchasing of services from the provision of these services. Without the separation of the assessment and delivery roles, there will inevitably be a tendency to fit the user to the service, rather than the service to the user, although there will be circumstances in which assessors are obliged to provide services which cannot be adequately purchased elsewhere. The decisions of those involved in planning and assessment are vital in ensuring high quality, cost-effective services. Those that take them must, therefore, be democratically elected and held to account for their decisions. These principles suggest a model in which a democratically accountable assessor is able to purchase packages of services to match the individual needs of each client from a plethora of different providers, with money following the client.

2.0.5 Democratic accountability underpins this approach, and each tier of government has a role to play. The respective responsibilities of each tier of government should be:

- *At a national level*, to provide proper funding; set and safeguard standards; and provide information.
- *At a regional level*, to monitor the availability of local services, and plan and allocate resources to specialist health and community care services which cannot reasonably be provided locally. (Over time, as regional governments are established, some of the responsibilities of national government may be devolved to them.)
- *At a local level*, to assess the needs of the individual service users and the local community as a whole; ensure a range of local services and providers to meet those needs; provide information on available services; and coordinate locally the provision of social and health care.

2.0.6 Community care cannot be considered in isolation. The distinction between ‘health’ and ‘social’ care is a fine one and the boundary between them is often blurred. We would therefore seek to create a ‘single seamless service’ of care provision, based on:

- The principle that NHS-provided services should be free and available to all on the basis of need at the point of delivery.
- Much closer integration of social and health care services.
- The incorporation of health services planning into local government to ensure local democratic representation.

2.0.7 The ‘seamless service’ approach recognises the close links between social and health care, yet a successful community care policy must consider a whole range of other issues, such as benefits, housing and education.

Many Liberal Democrat policies contained in other policy papers would have a significant impact on improving community care provision. In particular, these include:

- Reform of the structure, funding and method of election of local government.
- Investment in housing, education and training.
- The reform of the tax and benefits system, and improvements to housing, mobility, disability and other benefits.
- The establishment of a bill of rights and comprehensive anti-discrimination and equal opportunities legislation.
- The creation for a Charter of Rights for people with disabilities drawn up in consultation with organisations for and of people with disabilities.

How Community Care Should Be Planned and Delivered

3.0.1 The Liberal Democrat approach is based on identifying two distinct roles of care assessment and care delivery; local accountability for the decisions taken; and the integration of health and social care provision. This approach leads us to make a number of specific proposals:

- District health authorities and social service departments be merged into single departments within democratically elected local authorities to plan and purchase the whole range of health and social provision.
- Regional health authorities be transformed into democratic regional health and social services authorities under the auspices of regional governments, as and when they are established.
- Community care plans which incorporate both health and social care provision and aim to mobilise public, private and voluntary sector providers.
- Enforcement of high standards in service delivery and rights to public consultation.

3.1 Merging Health Authorities and Social Services Departments

3.1.1 The 1990 National Health and Community Care Act transferred responsibility for community care from local health authorities to social services departments. The legislation made Social Services departments responsible, in collaboration with health authorities, for individual assessment and for securing appropriate services within available resources. Local authorities thus became the ‘lead

authorities’ providing community care. The objective was to enable them to build on their experience as the primary providers of community care, while breaking down some of the often artificial distinction between health and social care. While the concept of a lead authority is useful, it is inadequate in two respects.

3.1.2 First, it leaves the funding assessment and planning of health care outside local democratic control. Local authorities are thus placed in the unenviable position of being accountable for the decisions of others beyond their sphere of influence. For example, different health authorities use different criteria to define health care, ranging from those that fund care only where there is a positive health gain (i.e. the prospect of cure) to those that extend the definition of health care to include looking after long-stay patients with nursing needs. Central government grants take no account of the differing responsibilities undertaken by different authorities so that, at present, social services and health authorities have a perverse financial incentive to manipulate care packages so as to be able to disclaim financial responsibility.

3.1.3 Second, the concept of a lead authority increases the tendency towards the view that community care should provide social care with other elements tacked on. Individual care packages must give appropriate weight to health needs, recognising that in many cases, particularly those of multiple disability, health needs are actually dominant. Both inadequacies mean that decisions about which services to use are just as likely to be determined by variations in funding or administration as by the needs of clients.

3.1.4 Our objective is to replace this flawed arrangement with a single ‘seamless service’ which gives service users access to social and health care on the basis of need. The reintegration of social and health services would bring four distinct advantages:

- Care groups, such as older people, people with mental health problems or learning disabilities would benefit from the better coordination which is likely to result from the integration of all statutory responsibilities under a single authority.
- Social service departments would benefit from the availability of community medicine and public health skills.
- Local authorities would be more likely to take into account the health implications of decisions in areas such as housing, education and planning if they were responsible for meeting health care costs.
- The manipulation of care packages by social services departments and health authorities to avoid financial responsibility would cease.

Our objective is to create a single ‘seamless service’ which gives service users access to social and health care on the basis of need.

3.1.5 To achieve these benefits, both social and health care must be funded according to the same criteria, subject to the same administrative regime and held to account through the same mechanisms of local democratic control. *Liberal Democrats would therefore merge not just district health authorities and family health service authorities, but also social services departments within the same tier of local government (See Table 1, p16).*

3.1.6 Within each health and social services department, there would be clear professional lines of responsibility, so that professionally qualified staff report to professionally qualified staff. One model for such a department would be to appoint two assistant directors, one responsible public health and the other for social services. A further director would have overall managerial responsibility for both the health and social service functions of the department’s work. (This model is similar to that already employed in housing directorates, where surveyors have ‘technical’ line management, but sit alongside estate officers who ultimately report to a different assistant director.)

3.1.7 The process of transferring responsibility for public health from health authorities to democratically elected local authorities is described in some detail in Federal White Paper 5, *Restoring the Nation’s Health*. To ensure that any disruption caused by the transfer of powers is minimised we would delay it until the reorganisation of local government into unitary authorities, and until the separation of the planning of health and social care from its delivery has become widespread. At this stage, it would become possible to transfer health authorities merely by switching their line of accountability, from running upwards to the Department of Health in Whitehall, to running downwards to the local community, through its elected local authority representatives.

3.1.8 *The integration of local and health authorities should take place at the same time as the reorganisation of local government into unitary bodies.* Liberal Democrats broadly favour the establishment of single tier, most purpose ‘core’ authorities, reflecting natural communities throughout England. The functions and powers of such authorities, as well as their revenue raising powers and relationship to regional and UK government, is described in English Green Paper 5, *Shaping Tomorrow’s Local Democracy*. The establishment of such authorities will no doubt take some time. In the interim, all decisions with structural implications should support the eventual integration of family health service, health and local authorities. To a certain extent this is

already happening, with joint planning for care groups and the merging of district and family health service purchasing and planning functions.

3.1.9 Post-reorganisation, the combined social services and health authority would be responsible for assessing, planning and, in some cases, providing primary and community health services and local hospitals, long term specialist housing, respite care, residential and nursing homes, speech therapy, special needs education and so on. We welcome the fact that the balance between the use of public, private and voluntary sector providers may vary significantly from district to district, according to local needs and circumstances (see 3.3.3).

3.1.10 Liberal Democrats further recognise that the balance between public and independent sector providers may not necessarily be the same for health and social care. All GPs would be expected to work within the framework of services determined by the locally accountable authority, although this does not mean that the freedom of GPs to refer patients according to need would necessarily be restricted (see Federal White Paper 5, *Restoring the Nation's Health*). The position of GP fundholders will be reviewed in a future health paper.

3.2 Regional Health and Social Services Authorities

3.2.1 The case for the integration of health and social service planning and needs assessment holds true at a regional, as well as a local, level. Local services are at the heart of community care; but local services cannot provide for the whole range of specialist needs, and this will increasingly be the case if the predicted move to smaller unitary authorities occurs. Local authorities should not seek to provide every service locally, but to make arrangements whereby each one can be provided appropriately, which may include purchasing services at some distance. Specialist hospitals, and units which take referrals regularly from large geographical areas, cannot sensibly be

brought under the management of local authorities. Equally, more specialist social care, such as some types of long stay specialist housing or specialist needs education, needs to be assessed and planned regionally.

3.2.2 *For this reason, we regard moves towards the eventual abolition of regional health authorities as retrograde, and likely to result in the further centralisation of the NHS. Instead, we would transform regional health authorities into regional health and social service authorities (RHSSAs) with responsibility for longer term planning of provision and ongoing regional needs audits. RHSSAs would also provide an excellent forum for cross-district information exchange and joint planning. Prior to the establishment of regional parliaments, the membership of RHSSAs would be made up of elected members nominated from the districts, with health and social services professionals to advise them.*

We regard moves towards the abolition of regional health authorities as retrograde.

3.2.3 As regional parliaments were established, RHSSAs would be brought under their direct democratic control. We believe that those planning regional health and social services should be made more, rather than less, accountable to the local community. We oppose the continuing trend of transferring planning powers to unelected quangos. We would look to devolve functions of central government, such as resource allocation and the monitoring of standards, to regional governments rather than taking up powers from local government.

3.2.4 Since the services being provided on a regional (or even a national) basis are likely to be extremely specialised, the extent to which each authority will need to use them will inevitably fluctuate unpredictably from year to year. For this reason, we would create a

‘specialist services budget’ for local and regional authorities as a central contingency fund against which authorities could borrow according to their need for services provided on a regional (or in the case of regional authorities on a national) basis.

3.3 The Providers of Health and Community Care Services

3.3.1 The separation of the assessment and planning functions from the delivery of services is intended to boost the role of voluntary and private sector providers, and to diminish the role of local authorities as providers. In health, the Government’s reforms have further sought to reduce the role of local health authorities through the establishment of GP Fundholders and NHS Trusts as alternative purchasers and providers. The Liberal Democrats’ desire to incorporate NHS trusts within a common structure for the local management of hospitals is clearly spelt out in detail in Federal White Paper 5, *Restoring the Nation’s Health*. Both fundholding and trusts will be subject to further consideration within the context of the Party’s next health paper, to be published before to the next election. This paper is therefore primarily concerned with the provision of social care services and the delivery of individual care packages.

3.3.2 Currently, a wide range of bodies share responsibility for the provision of care across the public, private and voluntary sectors. This patchwork of provision has enabled users to choose between a range of services, dependent upon need. In an increasing number of cases, however, this ‘choice’ is inevitably restricted according to the contribution which each individual or their family can afford to make towards the costs of their own care.

3.3.3 The 1990 Health and Community Care Act requires social services departments to spend 85% of the funds transferred to them for the provision of community care in the independent sector. As a result, in the future more services will be provided by the private

sector and voluntary organisations. *Liberal Democrats do not oppose this shift in provision although local authorities must retain the capacity to be able to act as providers, particularly where services cannot be provided adequately by other means.*

3.3.4 We recognise that large scale, monolithic service provision has rarely been a success, and that often local authority-wide, social services have tended to be dominated by managerial concerns too remote to respond to individual needs. It is clearly difficult (although not impossible) for a large organisation to provide the range of flexible services required to meet individual needs appropriately. *Liberal Democrats therefore endorse the mixed economy of provision approach*, not as a result of any ideological partiality towards the private sector and financial competition, but because a plethora of different, small scale providers is more likely to offer the diversity and flexibility appropriate to meeting widely differing individual care needs.

3.3.5 Whether or not this enhanced role for the independent sector is a success will be dependent upon three conditions:

- *The overall level of funding provided for community care* to enable local authorities to purchase services on the basis of need, rather than finance.
- *The range of services available*, extending the choice of building blocks for individual care packages, and the success of local authorities in assessing needs and coordinating services.
- The procedures by which standards are monitored and quality guaranteed.

Funding is dealt with in Chapter Four. Below we consider the assessment, planning and monitoring of standards.

3.4 Planning for the Needs of the Community

3.4.1 All too often in the past the provision of services has been based on the *perceived* needs of various, supposedly homogeneous, ‘user’ groups, such as ‘people with physical or mental disabilities’, ‘people with learning difficulties’ or ‘older people’. Such classifications are insulting and generally meaningless.

3.4.2 Under the new legislation each local authority has been required to produce a community care plan for approval by the Department of Health. The purpose of community care plans is to create an environment in which services can be developed to meet identified individual needs, rather than users slotted into the services available. The shift towards individual needs assessment is welcome.

3.4.3 Comprehensive and realistic needs assessment is essential in ensuring the availability of the full range of services required. The failure to consider health care provision alongside community care draws into question the value of the current round of community care plans. *We support moves, in the short term, to make planning a joint function of health and local authorities and to incorporate both health and social care provision into community care plans. Such moves only serve to illustrate the need for the full amalgamation of health and social services in the longer term.*

3.4.4 The key elements of any health and community plan should be:

- Mechanisms for wide and regular consultation and review involving service users, carers and the community as a whole.
- Identification of likely health and social care needs through a biennial audit. The audit should look at the aggregate of individual needs, including those of people from ethnic minorities, rather than try to tailor individuals to services.

- The range of services which are available, and how these might be developed, with particular reference to the voluntary and private sectors.
- Identification of gaps in provision and how these might be met.
- The establishment of funding criteria and priorities.
- Arrangements for assessment and the distribution of information about services.
- Systems for case management and complaints procedures.
- Broad objectives to be achieved over the period of the plan, with identifiable targets.
- The relationship between these objectives and those of other key functions of local government, such as housing, education and planning.

A biennial audit to identify likely health and social care needs.

3.4.5 Of course, many of these elements are present within the better local authority plans. The most successful authorities tend to be those which have consulted widely at each stage in the production of the community care plan, circulating it to health authorities, trusts, GPs and their representatives, social services professionals and voluntary and private sector providers. Community care plans should be reviewed annually and published alongside the Director of Public Health’s annual report on the health needs of the local population (see *Restoring the Nation’s Health*, para 2.5.3)

3.5 Guaranteeing Standards

3.5.1 We are confident that our plans for health and social services will result in a high

quality service, responsive to the needs of local people. Decentralised decision making, in both the planning and provision of care, will encourage local initiatives, diversity and flexibility, to provide an expanded choice and increased quality of service. We believe, however, that minimum standards for health and community care should be set nationally, while ensuring that UK government resists the temptation to set ever higher standards for local and health authorities without also increasing resources.

3.5.2 The Department of Health is already responsible for overseeing and setting guidance for community care plans. This provision would be extended to require that plans be jointly approved by the Department of Health and the Department of Social Security. Together, they should monitor plans to ensure that the elements listed in 3.4.4 above are included.

We would make the Social Services Inspectorate independent and enhance the scrutinising role of Community Health Councils.

3.5.3 There are numerous elements in providing quality services. They include:

- The training and professionalism of providers and staff.
- The extent to which users and carers are involved in decision making regarding the services provided and the quality of the information on which decisions are based.
- The overall level of resourcing for community and health care, and assessment not just of the cost of services but also the cost/benefit ratio.
- The system of monitoring and evaluation of planning, assessment and delivery.

Chapter Four sets out proposals for increasing funding for community care, while Chapter Six deals with the education and training of staff. Below are our proposals for monitoring and evaluation.

3.5.4 Two principles underlie our proposals for the monitoring and evaluation of standards in social care provision. They are:

- The greater the number of providers, the greater the need for inspection and regulation.
- Local authorities should not be responsible for both providing and inspecting services.

3.5.5 *The current Social Services Inspectorate of the Department of Health should be made independent* and appointments to it be made subject to the scrutiny of the new national body of Community Health and Social Services Councils (see section 3.6).

3.5.6 Its role would be extended to include defining standards to be incorporated in contracts between local authorities and service providers. Such standards should cover rights to advocacy and assessment, the professional training of staff and rights of inspection without notice, as well as the usual health and safety standards. Centrally funded, local units of the Inspectorate, working alongside (but not inside) local authorities, would be responsible for the following functions:

- Maintaining the register of local community care services, including care homes, and inspecting those services (see 7.1.3).
- Publication and circulation of advice on good practice, environmental protection, training opportunities, successful innovations and so on.
- The closure of services which consistently fail to come up to set criteria or to make improvements, with local authorities statutorily obliged to make suitable alternative arrangements.

- Inspection and the enforcement of standards in local authority services.

3.5.7 Federal White Paper 5, *Restoring the Nation's Health*, proposes the establishment of a National Inspectorate for Health with a wide remit to examine issues such as access to services, quality control procedures and skill mix. The reformed Social Services Inspectorate would be expected to work closely with the National Inspectorate for Health. In the long term, as the functions of health and local authorities were merged, it would no longer be necessary to retain the separate Inspectorates and these would then be amalgamated.

3.5.8 In addition, *Restoring the Nation's Health* sets out a number of other mechanisms by which high standards in the health service would be guaranteed. Among its key recommendations are:

- A guaranteed sustained increase in funds for the NHS, including full allowance for health service inflation.
- A patient's charter guaranteeing rights to information and consultation, among others.
- An extended role for Community Health Councils, establishing a statutory relationship between them and all NHS units providing care.

3.6 Community Health and Social Services Councils

3.6.1 Community Health Councils enable users and their representatives to participate in discussions on the allocation of resources to and the delivery of health care services. *Restoring the Nation's Health* makes proposals to extend this role, matched by an increase in resources. Now, we would seek to extend it further to encompass social, as well as health care services. We would rename Community Health Councils Community Health and Social Services Councils (CHSSCs).

3.6.2 The recommendations in section 8.3 of *Restoring the Nation's Health* could be extended to encompass CHSSCs, to include:

- Raising awareness in the local community, and amongst other voluntary groups, ethnic minority communities and individuals using health and social care services, of any planned changes; organising public consultation meetings; and enabling residents to participate in planning such services.
- Identifying priorities for social services, highlighting gaps in provision and raising them with local or regional authorities.
- Giving advice and assistance with complaints to members of the public.
- Attending meetings of decision making bodies, with the right to contribute but remain independent.
- Monitoring and surveying the quality and standards of services provided (particularly human rather than statutory or contractual standards) and making recommendations to local monitoring units.

3.6.3 We would retain the current statutory responsibility of Community Health Councils to produce an annual report detailing developments in local health services, and extend this duty to include social services.

3.6.4 We would establish a national representative body of CHSSCs to consult with and advise the Department of Health on community interests and to scrutinise appointments to the Social Services Inspectorate.

Funding Community Care

4.0.1 The Griffiths Report and the subsequent NHS and Community Care Act was about the management and the delivery of services. Of course, such issues are essential to ensure high quality care, but of equal importance is the *resourcing* of community care.

4.0.2 In recent years, the level of funding for community care has risen in real terms. The number of people being cared for has, however, risen more dramatically. For example, spending on local authority domiciliary and residential care in England has increased from £2,724 million in 1986/87 to £3,239 million in 1990/91 (*1992/93 Health Select Committee Report*). Over the same period, however, the number of people in Great Britain over pensionable age has risen by nearly 200,000. Similarly, the number of people registered as physically disabled increased by over 150,000 (13%) between 1984 and 1990. The latest OPCS disability survey (1986) suggests that there were then almost 6 million people with disabilities in Britain.

4.0.3 The largest increase in funding has been to meet the cost of the housing and income support for those in private residential homes, rather than their actual care costs.

4.0.4 Now in the shadow of a £50 billion budget deficit, the Government is trying to rein back public expenditure. It has used the long-awaited transfer of responsibility for residential care services from central to local government as a cloak for cutting back resources for community care. The transfer was underfunded by £20 million this year (1993/94) and the Government may attempt to make further cuts and blame them on local councils. In the light of Council Tax ‘capping’ this accusation is patently absurd.

4.0.5 We support the transfer of resources to local authority social service budgets, but the transfer must not be a cover for cost cutting. Many community care providers - public, private and voluntary - are experiencing sharp falls in revenue. It is as yet impossible to tell whether this trend will continue as most funding is based on short-term planning cycles, leaving users and projects uncertain about their future and unable to invest over the longer term.

4.0.6 Liberal Democrats believe that the funding of community care must be given a high priority. Inevitably, however, it seems unlikely that demand can ever be fully satisfied; there will always be more that could be done. Consequently, priorities must be set within community care. Such priorities must be based on negotiation and consultation with local people and, when agreed, publicised and periodically reviewed within community care plans. Priorities must also be set within a long term planning framework which sets a shared context for providers and users.

4.1 Ring Fencing Community Care Budgets

4.1.1 The issue of ‘ring fencing’ or prescriptive or exclusive budget setting by central government is a necessary element of any discussion on the nature of funding of community care services and has been made so by the restrictions placed on local government funds. In allocating budgets for these services to local authorities, Government bowed to calls by councils of all political complexions, voluntary agencies and others to ring fence funds. As a result, community care budgets are to be ring fenced within local authorities’ total budgets for the next three years.

4.1.2 Over the long term, Liberal Democrats believe that ring fencing distorts local government expenditure and takes away the power of local authorities to determine local priorities. The case against ring fencing can be simply summarised:

- Ring fencing allows central rather than local government to determine local spending priorities.
- Specific budgets tend to be treated as ceilings on expenditure as well as minimums.
- It is difficult to make out a case for ring fencing community care which could not equally be applied to other local services.

Under a future Liberal Democrat government capping restrictions would be lifted, local government funding reformed and fair votes introduced, to enable local voters to hold councillors properly to account for their decisions. In the short term, however, in the particular circumstances of the transfer of funds from central to local government budgets, and while the current restrictions on local government finance remain in place, it may be argued that the case for ring fencing is different.

Funding priorities must be set after negotiation and consultation with local people.

Support for Ring Fencing for the Short Term Only

4.1.3 Over the past fourteen years, the Conservative Government has cut back local government funding and restricted, through capping, the capacity of councils to raise their own revenue, so that central government now determines the majority of local government funding. At the same time, the Government has

loaded significant new responsibilities on to local councils. In particular, it has transferred responsibility for funding the residential care costs of older people to local government. While - and only while - these conditions persist, the case for continuing ring fencing is overwhelming.

4.1.4 This Government has attempted to set national standards for community care, but has not provided the resources with which to meet these standards. Broad cuts in the funding of local government and unrealistic standard spending assessments have left many local authorities struggling to pay for community care. Ring fencing would ensure that, in the context of transferred funds, any money newly available to local authorities is spent on community care.

4.2 Paying for Services

4.2.1 The current benefits system is inadequate to enable people with disabilities to meet the additional costs of their disability in full. Liberal Democrats are committed to improving both the level and availability of disability benefits. Our proposals for reform of the tax and benefits system will be laid out in more detail in a future policy paper.

4.2.2 *This policy paper argues that individuals should, as far as possible, be able to determine for themselves the nature of the care which they receive.* Were disability benefits to be adequate, Liberal Democrats would wish to leave individuals to choose for themselves which social services to purchase, rather than have some other body purchase them on their behalf. Health care provided through the national health service must, of course, remain free at the point of delivery.

4.2.3 Disability benefits are not, however, adequate and so many service users are not currently able to bear the full costs of the services they need. Local authorities should not be forced into the position of having to charge for social services. Government capping and underfunding, however, leave some local

authorities with little choice: either they introduce charges or they are forced to close services. *If local authorities are forced to introduce new charges then the Conservative Government must take the blame.*

4.2.4 Liberal Democrats believe that it is up to the elected representatives of each local authority to determine their own priorities for expenditure. Each local authority must be accountable for its decisions, but to local electors, not distant government departments with little idea of local circumstances. Where

local authorities decide they have no choice but to introduce charges, that must ensure that:

- Charges are not a determining factor in the make up of individual care packages.
- All those with care needs have access to a full range of social services, especially those on, or just above, income support.
- Charges are applied at a low rate to a range of services, so that the burden is shared equally among all services users, not confined to particular 'groups' of users.

Putting the User in Charge

5.0.1 The large number of people who have particular health, communication or mobility needs share the same overall desire as anyone else for a good quality of life. Quality of life for them can simply be defined as receiving adequate services commensurate with need and being afforded the same dignity and respect as any other person. That means a safe, clean, affordable and accessible home; warmth and food; mobility and transport; reliable health care; and personal and financial security. The reality is that, whilst care and other services are often geared to meet individual needs as far as possible, the rhetoric of the individual as a 'health consumer' or 'client' is not borne out. The individual has little say in determining their own services and scant recourse to appeal as other 'consumers' have. Additionally, people with disabilities face continual discrimination, obvious and subtle, from professionals and public alike.

The first step to put the user in charge is to remove from them the need to rely unnecessarily on social services.

5.0.2 Liberal Democrats are determined that each individual user should be put in charge of the care they receive to the greatest possible extent. This requires three steps:

- *A social security system and social policy which can address the basic requirements of the vast majority of those with care needs.*
- *Individual packages of care for those who will still need social services, aimed at enhancing independence.*

- *Advocacy and self advocacy* to ensure that users' voices are heard, that they understand their rights properly and that, as a result, their needs and aspirations are met.

5.1 Creating a Framework for Independence

5.1.1 The first step to put the user in charge and to raise their quality of life is to remove from them the need to rely unnecessarily on social services in the first place. The provision of high quality educational, employment, health care and social opportunities for older people and people with disabilities - set within the framework of a just and realistic social security system - is a sound investment for a government interested in the quality and cost effectiveness of care.

5.1.2 Liberal Democrats have put forward a raft of different proposals which would improve the quality of life of many of those people who currently rely on community care. In some cases, such proposals would remove their reliance on social services altogether. These proposals include:

- *The establishment of comprehensive anti-discrimination legislation* and a Charter of Rights for people with disabilities, drawn up in consultation with organisations of and for disabled people.
- *Significant improvements to disability benefits* to acknowledge the extra costs faced by people with disabilities.
- *Further improvements to the level and administration of Invalidity Benefit.*
- *A substantial increase in the level of the basic state pension* and its division into two parts to allow for an extra element to

provide additional help for those in the greatest need.

- *The inclusion, wherever practicable, of children with disabilities within mainstream education* and, where this is not possible, the provision of high quality specialist education.
- *A package of measures to make it easier for employers to take on people with disabilities*, including training grants, monitoring and enforcement of existing employment opportunities laws in the Disabled Persons Act 1986.
- *Increased investment in the NHS.*
- *Improvements in access* to transport, buildings and leisure services.

5.1.3 These measures and others are spelt out in more detail in Federal White Paper 2, *Partners for Freedom and Justice*, and Federal Green Papers 11 and 31, *Common Benefit* and *Retirement with Dignity*. Policy papers are now in preparation updating the Party's tax and benefit proposals and expanding upon those for people with disabilities.

5.2 Individual Care Packages

5.2.1 The post-Griffiths approach to community care quite rightly focuses upon the individual needs of service users. It moves away from the old local government approach of devising a number of services to meet the perceived needs of various ill-defined 'user groups' with criteria to determine who may or may not make use of such services. The post-Griffiths approach has three key components:

- *Individualised funding*, whereby a capped budget is allocated to address the needs of a user through the purchase of a range of different services from different sources.
- *Advocacy*, the means of identifying individual needs and aspirations of service users and their carers.

- *Personal support networks*, providing rights and opportunities to individual service users.

5.2.2 Liberal Democrats are fully committed to the principle of establishing individual care packages, underpinned by individualised funding. The success or otherwise of an individual's care package depends, however, upon getting the assessment of needs right. The 'right solution' will vary from individual to individual: *individual assessment must be firmly founded upon the views, aspirations and perceived needs of the client and existing carers*. Advocacy may well be necessary to ensure that these views are taken fully into account (see section 5.3).

Individual assessment must be firmly founded upon the views, aspirations and perceived needs of the client and existing carers.

5.2.3 *Locality Teams*: Liberal Democrats support the establishment of expert locality teams, based on primary health care teams, to assess the individual's needs and to oversee the delivery of services. The role of locality teams is to enable clients and their carers to understand what can (and cannot) be done, and to help them to make an informed choice about available services. Teams should make a detailed assessment of each individual's needs based upon face-to-face interviews with users and carers, careful evaluation and negotiation. Locality teams should consist of representatives of all those who are, or may become, involved in providing either health or social care services, including GPs, social workers, health visitors, community nurses, speech therapists, home help providers, housing officers and so on.

5.2.4 There is an obvious conflict between the responsibility on locality teams to produce detailed and thorough assessments and keeping

the procedures open, simple and speedy. To counter the tendency for bureaucracy to run riot, locality teams should:

- *Produce easy-to-understand information* on the assessment process and the available services.
- *Publish recommendations in plain languages* and in other formats appropriate to the needs of the client.
- *Complete the assessment within appropriate statutory time limits.*
- *Review the assessment biennially* with the right for the user or carers to request an earlier reassessment should circumstances change significantly.

5.2.5 *Key workers:* One essential member of the locality teams should be the key worker or case manager. Liberal Democrats support the extension of the key worker system, already operated by the best local authorities. The role of the key worker is to act as a single point of contact between users and carers on the one hand and locality teams on the other. The key worker should have some direct budget responsibility and thus be able to adjust services to fulfil the needs and aspiration of users.

***Given the right information,
many people make
their own best advocates.***

5.2.6 *Appeals:* Even with the substantial improvements which we are proposing, there will inevitably be occasions on which individuals are unhappy with their assessments. In such cases they must be able to appeal against their assessment. We would simplify the current over-complicated appeals procedure. Under our reformed process appeals would be made in the first instance to the key

worker, then to an independent local appeals panel (see 3.5.5), and then to the judiciary. Because the key worker has such a central role in the assessment procedure and because the relationship between the user and their key worker is so important, users should, where possible, be offered a choice of key worker and should be able to request a change if the relationship does not work.

5.3 Advocacy, Self Advocacy and Individual Rights

5.3.1 A system of community care based upon individual care packages depends for its success upon a clear understanding of the needs and wishes of each individual. This in turn requires an effective system of advocacy. Many users are not aware either of their rights or of the services available to them. Given the right information, many people would make their own best advocates. The rights of service users must include:

- *The right to assessment.*
- *The right to reassessment* after two years or following any material change of care needs.
- *The right to information*, including a clear, written statement of services to be received, review and complaint procedures in a language or form that the user and their carer can understand.
- *The rights to complain.* Each local authority must establish and publicise a clear and simple complaints procedure.
- *The right to appeal.* (See 5.2.6)

5.3.2 An important role of local authorities therefore is to provide comprehensible and comprehensive information about rights, benefits and services to help facilitate self-advocacy. *Liberal Democrats would support the formation of self-advocacy or self-help groups through the community care grants of*

local authorities. We would look at providing training programmes to help individuals develop the confidence and the sense of self worth necessary for effective advocacy.

5.3.3 There are circumstances in which users are not the most effective advocates of their own case. In such cases, the use of an advocate must, wherever possible, be through choice, rather than prescribed. People often like to use friends and relatives to act as advocates, as well as more formal advocates, normally social services departments and voluntary organisations.

5.3.4 Liberal Democrats are keen to promote effective advocacy. All individuals should be able to exercise their rights to appropriate care services, through access to information and to fully trained, adequately funded advocates. It is our belief that advocates should, wherever

possible, be wholly independent of care managers or service managers. Thus, advocacy is a function best performed by the voluntary sector, which already undertakes much advocacy. The voluntary sector should be grant funded by regional authorities to provide advocacy.

5.3.5 As the role of the voluntary sector as a provider of services expands, it may become necessary to review its advocacy function. We believe that the situation where an organisation - independent or public - is both an advocate and a key service provider should be avoided wherever possible. This principle need not, however, prevent an organisation from taking an advocacy role in one part of the country and a provider role in another. Local authorities must remain ultimately responsible for ensuring that advocacy is available to all users and, in the last resort, for providing it themselves.

Caring for the Carers

6.0.1 Community care involves assisting individuals to maintain their independence for as long as possible, offering them support to enable them to play an active role in society, and offering them the choice of continuing in their own home or another setting. As such it requires the cooperation of a huge range of people who ‘staff’ community care either formally or informally, with or without training, and with or without payment. They include friends and relatives, neighbours, volunteers and health and social care professionals, clergy, police and bus drivers, shopkeepers, publicans and milk deliverers, and in fact anyone with health, social service, social security, employment, education, leisure or other responsibilities.

6.0.2 This chapter considers the role and position of all those involved in providing care, in whatever form, from informal family carers to the most highly paid professional. As identified elsewhere, the boundaries between health and social care are indistinct and many service users consider their GP to be the person primarily responsible for providing care. For this reason this chapter should be read in conjunction with Chapter 6 of *Restoring the Nation’s Health, Staffing the NHS*.

6.1 Training for Professional and Informal Carers

6.1.1 There are more than 150,000 professional staff involved in public sector community care provision, including 5,500 senior management staff, 25,000 staff with assessment/care management responsibilities, 12,000 middle managers, and 115,000 in direct delivery of care and support. There are at least the same number working in private and voluntary sector provision.

6.1.2 These figures pale into insignificance, however, when set against the estimated six million carers (1984 General Household Survey). 3.7 million of these carers carry the main care responsibility and 1.4 million of them devote at least twenty hours per week to caring (and many of them devote a great deal more).

6.1.3 Given the huge range of services and the development of individual care packages it is becoming increasingly important for all these people to be aware of the role of services provided by others. This requires a multi-disciplinary approach involving staff from all caring professions, as well as informal carers, and considerable flexibility in staffing and pay structures. It involves significant cooperation, not just between health and social care professionals, but also with others working in housing, education and employment as well as other fields. *The ultimate objective must be that every one involved in the provision of care, in whatever capacity, will be trained to meet the needs of service users.*

6.1.4 Regardless of the basis on which care is provided all carers would benefit from professional training with regular updates. The huge disparity between the numbers of paid and unpaid carers means that trained professionals are going to spend an increasing amount of their time teaching basic skills to others. Training must obviously be appropriate and tailored to suit the specific needs of the carers and take into consideration the individual needs of the people to whom care is being provided and the carer’s other responsibilities.

6.1.5 The first step must be to create a comprehensive framework for training and retraining professional staff, so they can hand on their knowledge and expertise to other carers. This framework must apply equally to employees from the public, private and voluntary sectors. Much good work is taking place already in this direction:

- The development of NVQs and the general increase in modular training to help people build up knowledge and competences according to job and professional circumstances.
- The introduction of refresher training as the norm in an increasing number of disciplines.
- The establishment of joint pre- and post-qualification training for nurses and social workers.
- The involvement of people with disabilities and carers in the provision of professional and other training, so as to develop an understanding of service users needs.

6.1.6 Significant progress is being made. There is, however, much more that still needs to be done. In particular, other key development areas are:

- *The reform of training to make it cross-disciplinary*, so as to increase flexibility in the deployment of professional staff, such as nurses, planners, managers, social workers and service providers. Such training should include secondments and update training.
- *The development of expert resource teams* to provide back up for less experienced providers in areas such as challenging behaviour.
- *The opening up of training opportunities* to people from a wide range of services outside social care, enabling them to help provide support to people with disabilities using their services.
- *The development of the National Register for Carers, Assessors and Verifiers* to act as a means of communications to all carers, facilitating the distribution of guidelines for carers.
- *The provision of information and practice training* adequate to enable a smooth transition of care from professional carers to an informal carer.

6.1.7 The fact that the vast majority of carers are unpaid and voluntary does not necessarily mean that they are unprofessional in their approach. Many carers want to improve their skill and Liberal Democrats would wish to see all carers taught skills appropriate to their specific requirements. In addition, unpaid carers should be able to develop their talents further and have their achievements formally recognised.

All carers should have access to training and must have their achievements formally recognised.

Liberal Democrats would:

- *Encourage relevant training for informal carers* with ‘a record of achievement’ summing up their skills and abilities (see 6.1.5).
- *Ensure that training courses lead to recognised qualifications*, enabling unpaid carers to have their experience recognised through credit accumulation and thus be able to move on to more formal positions. (Training credits should, of course, include the appropriate theoretical background, such as the importance of risk-taking and the values of independent living.)
- *Actively encourage people with disabilities to take part in a training programmes* for carers.

6.2 Other Support for Unpaid Carers

6.2.1 Of course, training is only one component to improve the position and status of the army of unpaid and voluntary carers without whom care in the community could not function. Current policies exploit rather than value the role which carers play in society,

failing to recognise the work they do. Our objectives are to:

- Provide proper *financial support* for carers.
- Guarantee rights to *respite care*, advice and counselling.
- Ensure rights to have their *own needs assessed separately*.
- An assurance that *nobody would be forced into a carer's role*.

6.2.2 *We reiterate here our commitment to the transformation of the inadequate Invalid Care Allowance into a proper Carer's Benefit.*

At the last election, the Party manifesto explicitly committed us to increasing the value of the new Carer's Benefit by an immediate 15% over the current Invalid Care Allowance and indexing its future value to earnings. Wherever practicable, the person receiving care should be able to determine who their principal carer is.

6.2.3 Of the one million full-time carers in Britain only 195,000 qualify for Invalid Care Allowance. Older carers make up just 5% of those in receipt of the Allowance, although 45% of those caring 50 hours a week or more are over retirement age. We are committed to amending the entitlement rules to enable carers to combine caring with part-time or even full-time jobs and would phase in eligibility to the benefit for those over retirement age as resources allowed. In certain circumstances, Liberal Democrats believe it may be appropriate for a Carer's Benefit to be divided between a number of different carers on a pro-rata basis, particularly where the alternative to such informal care is expensive residential care.

6.2.4 There are many ways other than financial support in which it is possible to demonstrate our appreciation for the work of carers:

- *Accessible information and advice*. This should be a standard element of any Community Care plan.

- *Support and respite care*. Increased cooperation between health authorities, social services, GPs and voluntary organisations, all with adequate resources, would make it possible to provide flexible packages of respite care, ranging from sitting services, through day care to temporary residential placements.
- *Partnership*. Unpaid carers are often those best placed to know about the needs and aspirations of services users. Carers must be intimately involved throughout the process of needs assessment and professionals should seek their advice before embarking on any programme of care.

6.2.5 The individual needs of carers must be assessed and acted upon separately from those of the people for whom they care. For example, many of those who care for older people are themselves elderly, or are children; the people being cared for may have behavioural difficulties that make life intolerable for the carer or the carer may have been forced into the carer's role by circumstances or by the wishes of the person for whom care is being provided. *Liberal Democrats believe that the quality of the carer's life is of just as great an importance as that of the person for whom care is provided. This principle informs our approach and all our policy proposals.*

6.2.6 Our community care programme would provide support to carers to enable them to continue in that role for as long as they wish or feel able. It would also recognise that a point may be reached at which carers no longer feel able to cope without help. In such circumstances, we believe that they should be involved in determining the form and balance of continuing care. This right to consultation should be retained even if the carer ceases to be the primary provider of care.

Bringing Together Residential and Nursing Care

7.0.1 The ‘care in the community’ philosophy is rightly geared towards facilitating independent living. It assumes a significant increase in home-based care at the expense of residential care. We recognise, however, that there continue to be circumstances where residential care remains desirable or even essential. In particular, we recognise that many drug and alcohol abusers may benefit from living in sheltered accommodation where, away from the temptation to re-abuse, the opportunities for rehabilitation may be greatest.

7.0.2 Accommodation therefore needs to become an explicit part of individual care plans. Local authorities must be held to account if vulnerable people are made homeless or are inappropriately housed. Decisions as to where and in what form residential care should be provided should take into account the following factors:

- The wishes and views of the user and carers.
- The long term, as well as the immediate, health and social care needs and resources.
- Social factors, such as maintaining contact with family and friends.

7.0.3 To meet these all factors it will continue to be necessary to provide a wide range of residential care placements and community-based accommodation. Care homes should be encouraged to develop specialist care and we particularly favour the further development of continuing care complexes which facilitate appropriate care without unnecessary ‘move-ons’.

7.0.4 Success in finding a suitable and appropriate placement for an individual will be dependent upon the level of consultation, cooperation and negotiation between users and carers on the one hand, and health and social

services departments, housing departments, housing associations, GPs, health and care professionals, and voluntary organisations on the other.

7.0.5 The biennial audit of needs proposed in 3.4.4 should help to identify the most appropriate mix of residential accommodation for each local authority area. The audit should ensure that the views and needs of marginal groups, such as drug users, are properly represented in community care plans.

7.1 Merging Nursing and Residential Homes

7.1.1 Residential accommodation meets a wide variety of different health and social care needs, ranging from small units offering supportive environments for people with mental health problems or learning disabilities to places offering full nursing care. The majority of residents require both social and medical care, although to widely differing degrees. *Our commitment to a single seamless service of care provision leads us to the conclusion that the distinction between nursing and residential homes is unhelpful. Liberal Democrats would therefore abolish it.*

7.1.2 *Liberal Democrats believe that NHS care must remain free whatever the specialisations of the care home within which it is delivered.* At present, the NHS is responsible for the direct costs of health care in nursing homes. This is not, however, true of social care costs in residential homes. The removal of the distinction between residential and nursing homes must not be used as an excuse for shifting the burden of payment for medical, nursing or other clinical services to individuals or their families. Locality teams should be responsible for determining the nature of the care to be delivered and hence responsibility for

payment. Their intervention should help to ensure that the NHS fulfils its current obligation to meet health care costs.

7.1.3 Liberal Democrats would make the local inspection units proposed in 3.5.6 responsible for the registration of care homes. They would be responsible for ensuring that staff in the voluntary and private sectors are suitably trained and qualified. Home Office clearance facilities would be made available to registering bodies.

7.1.4 The Health and Social Services Inspectorate (see section 3.5) would be responsible for establishing standards for care homes and monitoring the work of inspection units. It would have the power to order improvements to be made to homes and, *in extremis*, order closures.

7.1.5 Local health services, such as physiotherapy, chiropody, occupational and speech therapy and continence care, must be available under the NHS to users, whether they are cared for in private or public sector care homes.

7.2 Paying for Residential Care

7.2.1 Paying for residential care is one of the major issues within community care. The question is 'who should pay?' Although the local authority should have responsibility for planning residential accommodation it should not be the universal provider. *We envisage a mixed economy of private, local authority, health authority and voluntary sector provision, so as to maximise choice and encourage competition.*

7.2.2 A mixed economy implies tendering. The criteria for performance must be strict and tightly drawn. These criteria should include the training of staff to include awareness of users' needs, and employment conditions. Tenders should only be accepted from equal opportunity employers, and conditions of employment should include sick pay and maternity benefits. Local authorities social services departments should be able to tender on an equal basis with private and voluntary sector organisations.

7.2.3 There is increasing evidence that some homes are charging rates well in excess of DSS or local authority limits and that many older people and their families are experiencing great hardship as a consequence. This is clearly the result of the unrealistically low level of funding available to local authorities from central government for community care as a whole, and the over-strict rules governing eligibility for support. We would restrict the level of charges by:

- *Requiring all care homes to publish their charges, with local authorities maintaining a register of prices.*
- *Giving the Social Services Inspectorate the power to 'cap' excessive charges, after due warning and appeal procedures.*

7.2.4 In other cases, private homes owners face bankruptcy as a result of being unable or unwilling to charge anything like commercial rates for care. We believe that individual users should be enabled to pay a reasonable rate for social care. No person in residential care should be excluded from the opportunity to claim Income Support for their personal costs (with appropriate premiums), and Housing Benefit for the rent elements of their accommodation. Eligibility should be assessed on the basis of the needs and income of the user's household (carers and dependents), not just their personal situation. It should extend across all sectors - including local authority care homes - so that locality teams can make placements on the basis of the needs of the user, rather than who pays. *Income support payments should reflect the average costs of a placement within each local authority area.*

7.2.6 Where a user wishes to remain in their own home, we would support this wish and appropriate adaption where feasible. Other support services should be established to enable independent living to take place. Being realistic, however, the cost equation must be borne in mind and long term criteria for cost-effective support of individuals should be introduced.

Appendices

There is not space in this policy paper to deal with the perceived needs of individual groups of service users. Such needs were considered in some detail in the English Green Paper Agenda for Caring and will be reviewed in a future policy paper on disability. In addition, Federal Green Paper 31, Retirement with Dignity, looks at the rights and status of pensioners and older people in considerable detail. It was, however, felt necessary to make two exceptions to this general rule to cover policy areas which have not been considered adequately elsewhere. We have therefore attached two appendices to this paper, the first on children and young people and the second on people with mental health problems.

Appendix One: Children and Young People

Over the last few years a number of high profile cases, such as the Cleveland, Orkney and Rochdale child abuse allegations, have raised the issue of the provision of social services for children and young people up the political agenda. We must therefore tackle these difficult issues now.

It is important to view the particular experiences that children and young people have of social services departments against the wider picture of young peoples' legal rights and responsibilities. The age at which young people can be held responsible for their own decisions is an important consideration in determining the extent to which a local authority should be able to exercise care responsibilities over them. Children (commonly understood to be those up to the age of 12) and young people (12 to 18 years) should have access to the same social service provisions as anyone else. As with other users, it should be needs of individual children and young people which determine the type and

level of support they receive. This appendix should therefore not read in isolation, but instead as complementary to the other chapters.

Parents have a legal obligation to care for and support their children until the age of 18. Recent legislation, such as the Children Act, has reinforced the importance of this parental responsibility. Of course, there are circumstances in which parents will need extra help and support, where, for example, their child has a disability. In order to support such parents and meet the needs of children properly, children must be assessed at an early stage by a cross-disciplinary team. Needs assessment should be regularly reviewed. *We reaffirm here our commitment to integrated education where practicable; a commitment spelt out in more detail in English White Paper 6, Excellence for All.*

Social services and housing departments should be prepared to provide for the special housing needs of children and young people, as well as adults. We reject the exclusively family-based model of care, recognising that the needs of some children are actually best met by short or long term residential care. Efficient support mechanisms and networks must be established for the parents, carers and siblings of children with disabilities who may feel isolated, under stress or concerned.

Unfortunately, in some cases parental responsibility breaks down completely. In such cases local authorities must step in. Local authority care takes the form of fostering, residential care and placements with other members of the family. The Children Act 1989 has increased the advocacy role of social workers, to identify and secure the most appropriate placements for the children and young people within their care. It places the emphasis, quite correctly, on the needs and wishes of the child first and foremost, over and

above those of the parents. Unfortunately, this extra responsibility was not matched by an increase in the financial resources available to social workers and many local authorities have therefore found themselves quite unable to cope with the task.

For this reason, it is necessary to reexamine the responsibilities of local authorities with respect to children and young people. Liberal Democrats would require local authorities to:

- *Explain to children and young people their rights* under the Children Act and other relevant legislation in a style and manner appropriate to the age of the child.
- *Liaise with health, education, youth, leisure and community services and with the police* to identify children at particular risk from harm or abuse, ensuring that information, training and working methods are shared.
- *Continually review and reassess the local authority Child Protection Register*, and ensure that it is an indicator of known potentially serious cases, rather than an exhaustive account of cases of concern.
- *Instigate more stringent checks on the residential centres in which they place children* in their care. These checks should not only focus on a qualitative analysis of the care, disciplinary and staffing procedures, but also the nature of support and advocacy which is offered on leaving care.
- *Appoint as a priority independent children's advocacy officers* to work with children and young people in putting their views and concerns to agencies involved in protection procedures.
- *Protect young people with behavioural problems* and their carers, by ensuring that the authority has access to secure accommodation.

- *Facilitate the provision of counselling services* for children suffering from stress as result of parental marriage breakdowns.

Appendix Two: People with Mental Health Problems

One in four women and one in seven men in the UK are affected by mental health problems - from mild depression to psychotic illness - at some stage during their life. The majority of people with mental health problems can, with increased support, live fulfilling lives in the community; this is our objective. We believe that the aim of mental health services should be to enable all people with mental health problems to develop a sense of self worth, and to become fully integrated in society, within a framework of support and care.

Unlike many other forms of community care, care for those people with mental health problems has been driven largely by medical and health requirements, rather than by social care. Many people have argued that health authorities rather than social services authorities should take the lead in providing for this group. The mental health service has long been described as the 'Cinderella service' of community care, being overlooked in terms of resource allocations and political support.

We believe that mental health services should be accessible, comprehensive and available locally. The merging of health and local authorities would be a first step in addressing the imbalance between health and social care services for people with mental problems. It would bring the provision of mental health services directly under the auspices of local government, and fully within the scope of local community care plans.

A number of other proposals in this paper would improve the position of people with mental health problems:

- *Individual care packages* would be designed to be flexible enough to respond to changing mental health problems, without constant restarts and ‘move-ons’.
- *Rights for individual users* to determine the care which they receive.
- *Increased resources* for community care services.

The ageing of large mental health institutions and the development of the ‘care in the community’ philosophy has led to the provision of care becoming more localised. The transformation of mental health institutions into NHS Trusts has, however, slowed the process of localisation, as per capita funding arrangements are a disincentive to institutions to discharge patients.

Liberal Democrats support the local delivery of mental health services. We believe that Community Mental Health Teams, run by mixed groups of staff, and locally based Mental Health Resource Centres, backed up by beds in local general hospitals, are the right way forward for mental health care. We oppose the transformation of mental health hospitals into NHS Trusts.

Even with our proposals, there would remain a relatively small but highly visible group of people, suffering the long term affects of severe mental health problems, who fall through the community care net. These people do not come under the provisions of the 1983 Mental Health Act but are unable to provide for their own basic needs or protect themselves from danger. This is the group of people for whom services are inadequate. Liberal Democrats recommend a number of specific improvements:

- *An increase in mental health education initiatives.*
- *The denoting of people with mental health problems as ‘vulnerable’* under the terms of the Housing Act, placing on local authorities a responsibility to provide

suitable accommodation and support networks for them.

- *Encouragement for further community crisis intervention centres*, with overnight accommodation be encouraged.
- *An increase in financial and political support* so that research and development into the causes of mental illness can continue.
- *The extension of statutory rights to after care* under Section 2 of the Mental Health Act to those mental health patients who are not sectioned.

This Paper has been approved for debate by the Federal Conference by the Federal Policy Committee under the terms of Article 5.4 of the Federal Constitution. If approved by Conference, it will form the policy of the Party in England.

Many of the policy papers published by the Liberal Democrats imply modifications to existing government public expenditure priorities. We recognise that it may not be possible to achieve all these proposals in the lifetime of one Parliament. We intend to publish a costings programme, setting out our priorities across all policy areas, closer to the next general election.

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Note: Membership of the Working Group should not be taken to indicate that every member necessarily agrees with every section or every proposal in this Paper.

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