Promoting Independence, Protecting Individuals

Policies for a Caring Society

Policy Paper 60

LIBERAL DEMOCRATS

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Summary

Our Approach

Liberal Democrats believe in mainstreaming social care, taking not just a whole system approach but also a whole society approach, supporting communities not simply rescuing social casualties. Our approach is based on the principles of:

- Fostering self-help and self-reliance where possible.
- Empowering service users and maximising their opportunities for self-determination.
- Developing the capacity of local communities to address their own social care needs with the active support of elected local government.
- Recognising the massive contribution that carers make within the United Kingdom by offering them enhanced support.
- Making preventive work a priority within social care.
- Tackling abuse of vulnerable individuals.
- Valuing, supporting and developing skills in those who work in social care.
- Reforming institutional structures that act as a barrier to providing integrated and seamless care.

Key Proposals

We propose to empower service users by:

- Making access to direct payments for care services effective as of right rather than the present confused position.
- Supporting the development of user-driven cooperative and mutual care providers, which could be funded through direct payments.
- Strengthening advocacy services, particularly those from the voluntary sector.
- Facilitating the direct involvement of service users so that they become equal partners in planning and reviewing care provision.
- Encouraging adequate funding for consultation and user involvement.

We propose to support carers by:

- Aiming to increase the Carers Allowance to properly reflect the personal and financial cost of care, initially by extending the Carers Premium to all carers in receipt of the basic state pension.
- Ensuring local authorities give much greater attention to the needs of carers, driven by a carers strategy within the Community Plan.

We propose to care for children by:

- Ensuring the model of care used places the needs of children at the centre.
- Incorporating the UN Convention on the Rights of the Child into domestic law and establishing a politically independent Children's Commissioner in England as part of our proposed single Equality Commission.

We propose to care for adults by:

- Amending the Care Standards Act 2000 to incorporate human rights standards and statements on compliance into care contracts as a pre-condition for registration by Commission for Social Care Inspection.
- Outlawing age discrimination in the provision of services, not just in employment matters.
- Reforming legislation on mental capacity and the role of the Court of Protection to maximise the continuing scope for autonomy of those lacking full capacity.

We propose to protect vulnerable people by:

- Creating a single independent Commission for Care Standards and Inspection out of the existing Commission for Social Care Inspection and Commission for Healthcare Audit and Inspection, with clear statutory duties to safeguard and promote the welfare of both children and vulnerable adults.
- Developing the specialist skills required from health professionals, police officers, social services staff and others to identify abuse, to make a full assessment, to respond to help the victims and to seek to ensure that abuse does not re-occur.
- Placing Area Child Protection Committees on a statutory footing, with relevant agencies under a legal duty to participate, and giving the Chair of the ACPC a statutory duty to report directly to councillors any concerns about the ability of local agencies to contribute to child protection work.
- Streamlining the procedures for determining child protection court cases.

We propose to integrate social care with other services by:

- Transferring the commissioning role of Primary Care Trusts to elected Local Government at the same tier as social services, ending the arbitrary separation between health and other local services.
- Using the Community Planning process to ensure care needs are addressed holistically, bringing in issues such as provision of appropriate housing, community facilities, and design of the physical environment.
- Integrating health and social care planning for specialised services at regional level in the context of broader regional strategies as part of our programme for the development of elected Regional Government in England.

We propose to improve resourcing for social care by:

- Implementing our general programme for reform of local government finance, including making substantial savings from the abolition of the discredited and expensive system for the collection of Council Tax.
- Making efficiency gains from ending the duplication and bureaucracy of separate health and social care commissioning.
- Abolishing the Government's 'bed-blocking' fines, and directing funds set aside for it straight to local authorities to pay for investment in capacity improvement such as community, intermediate and long-term care.
- Establishing a comprehensive, independent review on the overall level of resources required for social care, modelled on the Wanless Inquiry into healthcare resources.

We propose to address charging for social care by:

- Abolishing charges for personal care for those in long-term care, as recommended by the Royal Commission on Long Term Care and already implemented in Scotland.
- Critically assessing the consequences of the current charging policy for non-residential care services within the comprehensive review of social care funding.
- Ensuring the Department of Health issues clear guidance to implement the judgment of the Court of Appeal in the 1999 *Coughlan* case, that where a person's primary need for accommodation is a health need, then the patient's care funding is the responsibility of the NHS and not the local authority.

We propose to value, support and develop skills in those who work in social care by:

- Establishing clear careers paths for personal development with social care work.
- Encouraging the development of management skills with enhanced ancillary support and provision of effective IT systems.
- Encouraging entry to social work from a diverse range of people and movement between health care, social care and other related types of work.
- Reforming the inspection process so that it works to support and develop the skills of practitioners, including through abolishing the arbitrary and meaningless 'star rating' systems.

Note on Federal/State applicability: the great majority of this Policy Paper applies to England, with the main exceptions of proposals on the Carer's Premium and VAT treatment which are Federal and reform to the Court of Protection which is England and Wales.

Introduction: Principles and Values

1.1 A People Centred Approach

1.1.1 The starting point for any Liberal Democrat social care policy must be the promotion of the liberty of individuals and families enslaved by their poverty, health or social circumstances, their dependence on others or social or family circumstances and attitudes which would hinder their personal development and fulfilment at whatever age. The promotion of liberty depends on the recognition that each person has a unique value, a right to self-determination, social justice, and a claim to live as an equal in their community. It follows that all our policies must be framed with these intentions:

- Sustaining and fostering self-help and self-reliance wherever practically possible.
- Understanding what interventions are effective in preventing deterioration and dependence.
- Ensuring that where needs require a substantial and long term investment in the care of individuals, that the services promote the personal autonomy, development and fulfilment of those they serve.

1.2 The Role of Social Care

1.2.1 Until 1968, personal social services were provided by a number of local authority departments (health, welfare and children's), complemented with provision by voluntary, self-help and religious organisations. The Seebohm Committee of 1968 recognised the emergence of a social work profession and recommended the creation of integrated Social Services Departments offering a single door for access to services. This paved the way for large-scale state provision of social care. The vision offered by Seebohm was of a service reaching beyond the 'discovery and rescue of social casualties' to promote well-being through community involvement and prevention. Sadly this vision has not been realised.

1.2.2 By the 1980s it was estimated that the annual value of personal social services provided by government was £3,800 million, whilst those provided by charities were valued at £400 million, and informal care was estimated at £24,000 million. Over the last two decades the dominant factor in analysis of social care has been cost. Phrases such as 'the mixed economy of care' underpinned the focus of key policy initiatives such as the Griffiths Report and the NHS and Community Care Act 1990. Under the present government, the five Acts reforming the NHS and the Wanless report have taken this approach further. In the absence of a comprehensive analysis of future demand for social care, services such as residential and nursing care have been considered primarily in terms of costs to the health service. Of course, controlling costs and delivering value for public money are good things in themselves. However, along the way the preventive value of social care has been ignored, and as social services departments and emergent care trusts face increasingly detailed targets set by central government, the role and purpose of social care has been overlooked.

1.2.3 As Liberal Democrats, we see a need to review the role of social care. It is our belief that while there is a need to improve professional standards within social care, and to ensure that care given meets standards, the aim of social care must be to enhance, not replace care within communities. While there are some people who will always need considerable professional support, public social care policy should always be judged by

the effectiveness with which it enables people with needs to live within a safe, supportive community environment wherever possible.

1.2.4   For many service users social care intervention may be short term in order to help them through an acute crisis. For others help may be longer term. In both cases, the efficacy of care should be determined not, as now, solely by decreased use of health services, but also by the extent to which individuals remain as active participants and contributors to communities. This will be dependent on the whole spectrum of facilities and support services available, going beyond the kind of services which come under a 'social care' heading: in particular, availability of suitable housing, local shopping and leisure activities, and advice and information services.

1.3   Fostering Self-Help and Self-Reliance

1.3.1   This means a strong emphasis on support for those relatives, friends and neighbours who wish to become carers. The goal should be early identification of potential carers, bespoke support and appropriate recognition of the financial cost of caring through the tax and benefit system.

1.3.2   Personal and family self-reliance can be promoted through good information, personal control of services, and through other arrangements which encourage personal management of services. Community self-reliance can take institutional form through 'mutualised' arrangements and co-operatives which may provide, manage or purchase services.

1.3.3   The whole formal care system must be people-centred, assisting people with care needs to retain control of their lives, and valuing their views and experiences. Meeting social care needs means meeting the needs of each individual. Loneliness and loss of

confidence can be as debilitating as a long-term illness. Either through self-advocacy or independent advocacy people with care needs should be enabled to take charge of their care.

1.3.4   There are two main models that have helped shape policy and practice: the medical or technical model, which focuses on the disabilities and how they can be 'fixed'; and the social model, which focuses on the person and their abilities, viewing the disability as in the main caused by the environment and society. It is this model that has the greatest importance for the development of social policy aimed at enabling people to live full and fulfilling lives. Our goal must be to shift the centre of gravity in terms of the resources in our care system out of our hospitals and into the community; and power from organisations, providers and professionals to users of the services.

1.4   Self-Determination in Care

1.4.1   Some people will always need an environment providing total care, mostly only for relatively short periods of their lives. We must actively promote the commissioning of care in ways that protect and promote self-determination, independence and personal management of care services, while recognising the complexities of shifting patterns of investment, employment and provision. Improving and funding Personal Care Plans and formal advocacy support within a funder/provider model may assist in this. Crucially we need to extend models of care based on maintaining a person's ability to live in a home of their own. There is a hierarchy of independent living situations: first the home a person was living in at the time requirements for assistance arose; then another home adapted for independent living; then a sheltered living environment with secure tenure; then extra care housing with secure tenure; then an adult placement

within a regulated scheme; then residential/nursing home care. We should aim to enable people to live as far up this hierarchy as possible.

1.5 Prevention

1.5.1 Access to low level home help and timely provision of aids, adaptations and equipment, can make a significant difference to the level of independence a person can enjoy and reduce the need for acute NHS intervention, therefore unlocking resources and reducing pressures on the NHS. By tightening eligibility criteria and increasing charges for these services, local authorities have restricted access to these services to those who require the greatest help. There is a clear false economy in this logic. Prevention in the community rather than cure in hospital is better for the person, for their family and for the NHS.

1.5.2 Investment in early low-level home support can prevent the need for more intensive support and reduce the likelihood of hospital admission. Examples of the types of scheme that could be made more widely available include:

- 'Staying Put' and 'Handy Person' schemes where grants can be given to undertake a range of adaptions to a person's home.
- 'Home Security' schemes to prevent crime and reduce the fear of crime.
- Gardening services.
- Net and curtain cleaning services.
- Good neighbour schemes, informal self-help schemes where the currency is not cash, but time and skills.

1.5.3 As an overall measure to promote preventive care, we would broaden the scope of the Social Care Institute of Excellence to research and disseminate evidence based methods of preventive social care.

1.6 The Problem of Abuse

1.6.1 In March 2000 the Government published the guidance document *No Secrets* which required local authorities and other agencies to draw up adult protection strategies to tackle the abuse of vulnerable adults, including older people. The guidance was issued under Section 7 of the Local Authority Social Services Act 1970. Although this guidance is technically binding on Local Authorities, it is not a feature of the 'Delivery and Improvement' statements required of them and it is not binding on other agencies such as the Police. No new funds were earmarked to meet the extra costs of this work. As a direct result, while many local authorities have drawn-up strategies they have not made significant progress. Research by the charities Action on Elder Abuse and Counsel and Care suggests that the level of reported abuse significantly understates the true position. The implementation of practical multi-agency working to detect and prevent abuse requires funding.

1.6.2 The numbers of child deaths from neglect and abuse in the UK has not fallen for almost thirty years, and tragic episodes such as the death of Victoria Climbie reinforce the need for action. In the UK today, 36,000 children are on child protection registers at any one time and one to two children die every week from abuse and neglect. Inquiries into child abuse deaths are conducted in private and the majority are not published widely. Information about the findings of such inquiries is not systematically collected nationally and nobody is sure how many reports there are or where to find them. A Commissioner for Children in England would help ensure that children are better protected, by highlighting the problems with existing systems, making recommendations for necessary changes and pressing the Government to act on the proposals made by child abuse inquiries. Wales has already established such a Commissioner and

Scotland and Northern Ireland are consulting (see also section 3.3.8 on the Minister for Children).

1.7 Pressures on the System

1.7.1 According to the most recent survey of social service spending by the Local Government Association (LGA), budgetary pressures have continued unabated. In the year to March 2002, councils expected to overspend their budgets by £218m. Children's services account for two-thirds of the overspend. This is on top of the planned expenditure of £1bn in excess of what the Government thinks councils should be spending on social care.

1.7.2 According to the LGA, seven out of ten councils have tightened or propose to tighten the way they ration care as a way of controlling spending pressures. Only the most frail and dependent can be cared for.

1.7.3 Care is increasingly being rationed by:

- Denying any help to those with moderate care needs or with carers.
- Making those with high care needs wait either in a hospital bed or wait unseen in their own home.
- Setting limits either on how much the Council will pay for care or on the quantity or quality of the care provided.
- The impact of charging which deters some people.

1.7.4 Targeting of care on those in greatest need is leading to neglect of preventive and supportive measures which could be more effective in maintaining both quality of life and independence, and in the long term be more cost effective by reducing the amount of acute or residential care needed.

1.7.5 The greater demands for care are creating an increasing gulf between the grant based on Formula Funding Share (FFS) which councils receive for social care, and what they actually have to spend. This creates both pressure on other budgets and pressure on the council tax.

1.7.6 Older people account for approximately 62% of social care service users, but only represent 47% of spending on social care. The Government Actuary's Department projects that the number of people in England aged 65 and over will rise from 7.8 million in 1996 to 12.4 million in 2031, an increase of 60 per cent. The number of very elderly people (aged 85 and over) will rise even more rapidly, from 0.9 million in 1996, to 1.7 million in 2031, an increase of 88 per cent. This rise has been under way for many years, but there has been a lack of forward planning by government to take account of it.

1.7.7 Between 1996 and 2001, the number of 'children looked after' or in care in England rose from 50,600 to 58,100, an increase of 15%. There has been an increase of 55% in the number of 'children looked after' who have suffered from incidences of abuse or neglect.

1.7.8 Other factors behind the increased demand for children's services include:

- Parental drug and alcohol abuse. Even relatively low levels of substance abuse can contribute to problems for children and families.
- A higher survival rate and greater life expectancy of children with disabilities.
- Two thirds of children with disabilities have more than one impairment, a quarter have 5 or more impairments.
- The number of family break-ups has risen sharply, as have pregnancies outside long-term relationships. As a result there are more single parent families.
- Increased poverty puts more pressure on services. There are a growing number of children living in households with incomes below half average income.

1.7.9   Two thirds of 'children looked after' are placed in foster care, but Social Services Departments are finding foster carers increasingly difficult to recruit.

1.8   Institutional Problems

1.8.1   The institutional divisions between health and social care make it difficult to ensure a seamless service or to allocate funding rationally to achieve the best outcomes. Having two organisations with a multiplicity of different funding streams, different budget cycles, incompatible accounting regimes and computer systems, different accountability arrangements and competing cultures hampers effective policy development and service delivery. Good partnership working can only go so far to ameliorate these barriers.

1.8.2   An example of the difficulties caused by such institutional divisions is delayed discharges reducing the number of beds available in hospitals. Although unit costs are not always well established, the average weekly cost of treating a patient in hospital can be around five times the cost of supporting an older person in a nursing home in England. The different government funding approaches for the NHS and Social Services create an uneven playing field and fuels this problem. The Government response has been to impose a system of penalties on local councils for failing to expedite discharge.

1.8.3   The Government approach to delayed discharge fails to recognise that it is a symptom of a lack of capacity in the care home and home care sectors and consequential rationing of access to both. The imposition of fines is likely to undermine partnership working between the NHS and Social Services and do nothing to put in place the community services to reduce the need for hospital admission in the first place.

1.8.4   As proposed in the Wanless report, there must be a whole systems approach to health and social care. Investment in social care would reduce unnecessary costs to the NHS and make for a seamless provision of service.

1.8.5   Adopting a 'whole systems' approach requires investment in order that a range of services are developed and sustained to avert hospital admission, offer home based care and ensure an adequate supply of care home places.

Working Together for Well Being

2.1 Empowering Service Users

2.1.1 Liberal Democrats believe in the rights of the individual, and this naturally extends to users of social services. Service users should be able to exercise informed choices, and to take part at all levels in the provision of their care. This is linked to the seamless provision of health and social care services and the rights of carers.

2.1.2 The user should be at the centre of service provision, and offered real opportunities to become involved in the planning, commissioning and delivery of services. It must not just an exercise in ticking boxes and really needs to mean something to all those involved, not least to those receiving the services. The problem is that there is a danger of tokenism, and in many cases a resistance by professionals to the idea. There is also dispute about the level and nature of involvement which is appropriate.

2.1.3 Liberal Democrats have supported individual Personal Care Plans, with the funding following the user. We have also called for the extension of direct payments to older people and have always been committed to the idea. We also believe in extending the availability of advocacy services, whether self advocacy or by the services of another person.

Direct Payments

2.1.4 Direct payments are cash payments made in lieu of social service provision to people who have been assessed as needing services. They are a practical way of translating Liberal Democrat beliefs and policies into action and it is our goal to make such payments easier to access for all client groups.

2.1.5 Direct payments maximise choice and control for service users and should be encouraged. Liberal Democrats have historically encouraged them and facilitated their introduction early on in Kingston Upon Thames, for example. Although in theory Social Services Departments are required to offer direct payments, care managers often lack the knowledge and confidence required to encourage users to take up this option, and it is also viewed as more costly. There is a problem with the complexity, difficulty and lack of support for this option. However it can be extended across a number of client groups.

2.1.6 We therefore propose that local authorities are recommended to consult with service users on the best way to expand their direct payments scheme and draw-up a local action plan for promoting all aspects of the service, including financial administration and training. This might include the appointment of a senior Direct Payments Manager in Social Services to lead this work. The condition that someone has to be 'willing and able' to take up direct payments should be made more clearly understood and should not be clouded by resource issues, and fitting the service to people's lifestyles should be paramount. Further clarity is needed on who is entitled to the services.

2.1.7 There are many benefits to direct payments for service users, and they can be introduced to several client groups at an appropriate rate. Benefits include increased self confidence from the independence that comes with this system, and, to cite one example, one person has found it useful to employ a music therapist, so it is good for small providers.

2.1.8 Better ways to cope with direct payments, such as local groups in sheltered housing or other units, should be actively encouraged, along with the development of

independent living centres, such as the Sutton Centre for Independent Living and Learning. Mutuals and benefit organisations can play a part in this, and this is a burgeoning method of dealing with direct payments. There also needs to be more clarity around financial issues, such as whether individuals should be asked to pay VAT on their bills. There is pressure to ensure that private care agencies and domiciliary services have the same VAT treatment as public sector providers, which Liberal Democrats would support.

Advocacy

2.1.9   When someone is not confident enough to take up a direct payments option, and for many other reasons, they should have access to high quality advocacy services. These can be provided in a variety of ways, but we would especially recommend the funding by local partnerships of voluntary sector advocacy services, which would therefore be at arms length from the providers. Advocacy is especially important where we are encouraging personal care plans, with the money following the user. Any service user moving from one authority to another would have to be confident and articulate to negotiate their way round the new system and keep the money. Advocacy support is also vital for people with a learning disability, mental health problem or communication difficulty.

2.1.10 These, along with all services, should be culturally sensitive and sensitive to all issues of diversity. They should also not fall into some hole between social services and health, where health funding is taking the lead and social services get lost.

2.1.11 There is recent legislation on advocacy, in particular the creation of new Independent Complaints Advocacy Services in healthcare and the new duty on local authorities to provide advocacy support for children under the Adoption and Children Act. However it remains to be seen how this

will work in practice. We would aim to expand and clarify legislation in this field.

Consultation

2.1.12   Service users should be consulted at all stages of care planning and delivery, with real involvement and not just by token gestures. They should be consulted when there are real options available. If they cannot be present at meetings, the local authority should facilitate alternative ways for service users to participate such as teleconferencing, use of the internet, and postal and proxy voting. Service commissioners should take their meetings to where users are, such as bingo halls or day centres.

2.1.13   Many service users find it initially difficult to be involved, lay membership of panels and committees should be offered training and be properly rewarded to be empowered in their roles. Service users participating in meetings should be paid expenses for travel and childcare, and there should be a clear policy on the circumstances when they could be paid for their time. Liberal Democrats would also clarify the anomaly whereby users getting over a certain level of expenses for participation in these processes lose their benefits correspondingly, which makes a nonsense of the process.

2.1.14   Service users should be involved in selection panels for key posts and awarding contracts. All this needs to be properly coordinated and funded, with a separate line in the budget so it does not fall between stools. Service users are key to ensuring quality outcomes, and different levels of involvement are fine for different people and groups. We should also avoid overburdening particular people, and try to combat cynicism by producing real results as a consequence of consultation.

2.1.15 Service users can be involved in planning by sitting on commissioning

bodies, but there must be a full range of user interests represented, and some clear process by which user representatives communicate with local users generally rather than just follow personal agendas. They can be crucially involved in setting and monitoring standards, at the heart of the proceedings.

2.1.16 The process of involving service users should be transparent and on a regular basis, and they should be given the opportunity to participate at every stage. This should mean more people are involved and should help to combat cynicism. There will need to be a properly identified budget for publicity - to reach out to people - and for such mechanisms as consultative days or meetings of consultative fora on a regular basis. Access to services is very important, and users can have a valuable input in designing provision so that it is accessible, particularly, for example, transport. Staff training in working with users needs to be considered, and there is an opportunity cost of irrelevant services which are not valued by users.

2.2 Supporting Carers

2.2.1 There are 5.7 million adult carers in Britain, and 200,000 young carers under 18, who look after a relative, friend or neighbour who cannot manage without help because of frailty, sickness or disability. 1.25 million carers provide very substantial care of 50 hours or more each week. There is a significant turnover of carers: about 40% of carers start or end a period of caring each year. Many of us are likely to be carers at some point in our lives. Over their life times seven out of ten women will be carers and nearly six out of ten men.

2.2.2 Our society depends on the skill, commitment and good will of carers. It is estimated that the unpaid work of carers is worth £57.4 billion per year, this is roughly equivalent to the whole budget for the NHS.

2.2.3 In recent years national policy has started to recognise the contribution and support needs of carers through the Carers Recognition and Services Act 1998, the Carers and Disabled Children Act 2000 and the National Strategy for Carers (1999). However, the experience of many carers is that their needs are ignored or only partially met. The starting point for providing support to carers must be the recognition that they are the front-line of providing care. Health, social care and benefits staff need to see carers as partners and work with them in providing care and support. Their needs, which are highly individual, should be met alongside the needs of the vulnerable people they care for. All carers are entitled to a full assessment of their needs but this frequently is not offered in practice. Further, carers should be entitled to a full range of home support and respite services. Carers' needs should be assessed and met in relation to a wide range of needs including their health, care support, respite, leisure, work and education, housing, information and advocacy. We believe that carers deserve more than just words of recognition. We would aim to increase the Carers Allowance to reflect properly the personal and financial cost of care, initially by extending the Carers Premium to all carers in receipt of the basic state pension.

2.2.4 We believe that each Local Authority should include within its Community Plan a local carers strategy. The strategy should be devised in consultation with carers of all ages, carers groups and provider organisations. The strategy would inform the commissioning intentions of the local authority in discharging its new integrated health, housing and social care function. The strategy should map existing need and services and set out how unmet need are to be met. It should include young carers, respite care and advocacy and information services. Local strategies might also:

• Raise the profile of carers' assessments and ensure that all carers are offered full assessments.
• Give carers the right to access regularly

respite care provided in a way that meets their needs and those of the vulnerable person cared for.

- Promote new initiatives to meet and promote the health of carers. This will include such issues as stress, diet, and leisure / lifestyle as well as particular health conditions, as these are important issues for many carers.
- Ensure that training is provided for carers including lifting and handling (of those cared for).
- Promote initiatives in the use of the internet for carers. This could be used to help carers in networking and providing mutual support, and through the provision of information on services and educational opportunities while they are providing care at home.

2.2.5   At a national level we would improve employment legislation to ensure that employers respond positively to the flexible and changing needs of carers. This would include the provision of special leave for carers and carers transferring to part time working whenever this is possible for the employer. Also, we will consult with carers about how best to provide carers with help re-entering the job market after a period of caring.

2.3   Commissioning and Providing Care Services

The Purchaser/Provider Split

2.3.1   In 1990 the NHS and Community Care Act introduced the purchaser/provider split, which was seen as a means of.

- Making costs clearer enabling competitive tendering to reduce costs.
- Encouraging a wider range of providers.
- Weaning local authorities away from a culture of monopolistic provision.

- Improving and increasing the range of choice for service users.

2.3.2   The legislation led to local authorities taking overall responsibility for planning and funding the provision of care, while there was a move towards contracting with a broad range of providers. A greater spread between local authorities, private contractors and voluntary providers emerged, with an increasing trend towards externalisation, particularly of home care services and residential care, encouraged by a new regime of government funding which required 85% of funds transferred for community care to be spent on independent providers.

2.3.3   As set out in *Quality, Innovation, Choice,* Liberal Democrats favour an approach to public services based on public *funding* but a range of different types of *provision*. In this model, the key role of the public authority is in planning and purchasing care, and a clear separation between the purchasing and providing roles should allow a greater focus on developing the particular management skills needed for successful commissioning. It is important that the commissioning function attracts talented individuals and is given sufficient recognition and status, as it is the tool by which the needs of service users can be made paramount and new and imaginative services can be introduced. Commissioners have a key role in identifying the absence of necessary types of provision and acting to ensure those services are developed. For example, there is a general lack of services to meet the needs of severely disabled adults and children. It is a terrible missed opportunity if commissioners simply carry on buying the same types of care from the same types of provider on the basis simply of availability and cost.

Public Sector Providers

2.3.4 Social Services Departments, controlled by elected local councillors, are still the largest single employers in the social care field. Liberal Democrats strongly believe that the 'public sector' option must never be dismissed as some relic of the past, as too many on the Right appear to do. Many public sector providers offer extremely high standards of service, at good value for money. In the past, failing public sector providers have been reformed and turned round into successes. As generally large providers, local authorities are often able to support levels of training and staff development that are difficult for smaller organisations. Direct public provision may also in some circumstances be required where some types of service will simply not be provided by the private and voluntary sectors.

Private Sector Providers

2.3.5 Private provision can be of very high quality and the private sector can be particularly good at innovation and making specialist provision for particular groups of service users, an example would be specialist services for ethnic minority users. However, private provision is not always an option, for example, local authorities in rural areas have had difficulty in finding private providers of home care services.

2.3.6 There is a need to develop a more co-operative approach to commissioning services to ensure that private sector providers are able to invest. For example, there continue to be tensions between local authority commissioners and care home providers over the level of fees. This has been exacerbated by the Government's mishandling of the introduction of new care standards for elderly people's care homes. The result has been to put back the cause of good regulation and allow lower standards to be applied to the care of the elderly.

Voluntary Sector Providers

2.3.7 The voluntary sector, which ranges from small local organisations to very large national charities like Leonard Cheshire, has a proud and honourable tradition in the provision of social care. It has often been the pioneer of new services, in response to changing needs. It has played an effective role as an advocate for service users, particularly in the fields of mental health, learning disability and physical disability. Small-scale local voluntary groups have promoted self-help, built friendly networks of local support, and provided a broader range of support than professional institutions can. They can also go beyond traditional 'involvement' of those in social care, changing the relationship with professionals so that both are equal partners in the delivery of social care.

2.3.8 It is important that the state does not simply treat the voluntary sector as a disempowered delivery mechanism in order to get services provided on the cheap. Such an approach will tend to undermine community self-help, increase dependence on professionals and probably end up increasing costs in the long run.

2.3.9 To make the partnership between local authorities as care planners and purchasers and the voluntary sector as providers work to maximum benefit, we believe that care service commissioners need to take account of the special features of the voluntary sector, with appropriate training where needed.

2.3.10 Re-developing a network of self-help requires mutual support systems at neighbourhood level, like time banks or other systems that generate the co-production of services between professionals, clients, carers and their families. These can be based in NHS and other public service centres, and enable a level of mutual reliance - emphasising what people can do, rather than what they can't. Experience in the UK

and USA shows that this kind of approach can make a major contribution to the quality of life of people in social care, can help people to stay independent and can cut costs. For example:

- The children's mental health centre Abriando Puertas in Miami concentrates on the joint delivery of local social services, and a similar approach is being pioneered in the UK by the South London & Maudsley NHS Trust.
- The Rushey Green Time Bank in Lewisham has pioneered an approach whereby patients also act as volunteers, checking on people at home, doing basic DIY and providing neighbourhood support - with dramatic results for those involved.
- The US charity *Home, Safe* concentrates on training families in social care to provide permanent neighbourhood support for each other once the trained professionals have gone.

Co-operative/Mutual Providers

2.3.9   In addition to public and private sector options, care service providers may include social enterprise organisations. The key characteristic of such organisations is that although they may make an operating profit, this is reinvested into providing services rather than distributed to shareholders. Non-Profit Distributing Organisation (NPDO) is thus a better term for such bodies than the more usual Not-for-Profit.

2.3.10 In Policy Paper 53 *Quality, Innovation, Choice* (September 2002) we advocated a new legal vehicle, the Public Benefit Organisation (PBO), to resolve certain problems with existing co-operative structures and facilitate the development of new NPDO enterprises. This could include by transferring existing public sector provider units to PBO status.

2.3.11 Care services depend so much for their quality on the commitment and dedication of their workforce, and mutuals are potentially a structure which empowers the workforce more than any other. If the workforce feels that they 'own' their institution, it seems likely that they will also be more committed to their task. We believe that PBOs may also help to engender greater community support for local providers, as well as providing more freedom for the organisation's own development, both in terms of innovation and financial support. In the care field, user-owned mutual enterprises would be a mechanism for delivering user-centred services, with direct payments recipients pooling their resources to fund their service provision co-operatively.

2.4   Caring for Children

2.4.1   There are 376,000 'looked after', 'in need' or 'at risk' children in England and no single reason why they are there. Despite these children's care being under the supervision of the state it is remarkable how little it knows about the lives of these children and what happens to them when they become adults. From the available evidence, many children will never overcome the multiple disadvantages that they have experienced and will never have the opportunity to realise their full potential. For example, only 9% of children in care get 5 Grade A-C GCSEs, and 31% of children in care will go to prison later in life.

2.4.2   In practice, children are not at the heart of planning and delivering the services they need. Instead of helping, the care system can harm children through delays and buck passing. The experience of far too many children is not of a co-ordinated response to their needs involving social workers, health professionals, teachers, and carers. Children need parents, and if their birth parents let them down, they need to be able to turn to social workers, health professionals, teachers, and carers, who place their needs first and work to ensure a secure and

nurturing environment that can build a child's resilience and self esteem.

2.4.3   There is no systematic collection of data about the social, psychological or physical needs of vulnerable children. The delays in assessments, as well as multiple changes of placement can result in mental and physical health problems being missed. Better use of information technology can play a major part here. We are aware of some local authorities which have developed inter-agency databases of people under 25 with disabilities; this is updated monthly, and allows those on it or their carers to receive regular bulletins on availability of services. Entry on the database is voluntary.

2.4.4   Even those vulnerable children who are spotted find that no or slow referral to Children and Adolescent Mental Health Services (CAMHS) then compounds mental health problems further, and makes preventative steps almost impossible. In many areas CAMHS are hardly available at all.

2.4.5   There is an urgent need to rationalise the assessment tools used by agencies that work with children into a common assessment framework. The aim of such a framework would be to identify those children and their families who are vulnerable and need additional support. The development of a single assessment framework would also inform the development of protocols for information sharing between agencies.

2.4.6   The current system fails to recognise the needs of the child. It fails to look at the child as a whole; and ignores the effects of the child's surrounding environment of stability, schooling, healthcare, friends and family. Models of care for a child must focus more on preventive forms of care to ensure that any child has the opportunity to realise their full potential.

2.4.7   An example of such a model is the 'wraparound' approach as developed in San Diego and set out in the LGA paper 'Tomorrow's Children'. This definable planning process results in a unique set of community services and natural supports that are individualised for a child and a family to achieve a positive set of outcomes. It aims to build integrated services around the needs of the child and allows that child to continue in their home environment.

2.4.8   Liberal Democrats believe adopting the wraparound approach would:

- Deliver the services needed to keep children in their local areas by integrating and locating them in areas where the children go to school and their families live rather than removing the child to where the services are provided.
- Demarcate the way services are financed, adopting more multi-disciplinary cross pooling of funds with more flexibly across departments, and ensuring funding of schemes was measured in outcomes rather than inputs and outputs.
- Decentralise the way decisions are made by connecting neighbourhood residents and community stakeholders in decisions that affect their well-being.

2.5   Caring for Adults

2.5.1   We are concerned about the limited access due to rationing, and the poor quality of much of the social care services for vulnerable adults. The government focus has been on 'getting people out of hospital to free up a medical bed' rather than focusing on the quality of people's lives. Liberal Democrats will press for quality of service that provide positive outcomes for service users and their carers.

2.5.2   Over the last quarter of a century there has been a move away from institutional care to community care. But the closure of long-stay hospitals has not led to adequate resources being devoted to

providing services in the community. Government and local authorities must improve the level and quality of the full range of community based services, if vulnerable people are to be able to make real choices as to the service they receive. Further, Liberal Democrats will ensure that there are preventive services for vulnerable people who are living independently and so support them in an active lifestyle.

For Older People

2.5.3 We welcomed the thinking behind the National Services Framework for Older People when it was published in 2001. It promotes the need for 'seamless' services between health, social services and the independent care sectors and it advocates services that are user focused where older people are in the 'driving seat'. But it fails to give sufficient weight to housing and healthy ageing, and much of it is couched in terms of unfunded aspirations.

2.5.4 We are concerned about the limited availability of the range of community support services across the country. Frequently the quality of day care, home care and respite care services are poor. There is a particular problem in the lack of provision of specialist help for those with dementia and those who care for dementia sufferers at home. Government must encourage the development of home and residential based specialist dementia care and fund research and disseminate the findings on the best models of practice.

For People with a Learning Disability

2.5.5 We support the values and aspirations in the White Paper *'Valuing People'* to bring the opportunities of living in and fully participating in the community to all people with a learning disability. However, the Government has not delivered these improvements. There is much to do in

bringing the standards of services up to that of the best in providing living in ordinary housing, flexible direct care support, education and vocational training, and help to get employment and voluntary work.

2.5.6 We believe that the government did not go far enough in making Social Services the lead agency. We believe that Social Services should be the commissioner for all learning disabilities services and that the NHS budgets should be completely transferred to them. This long overdue change will be realised by our proposals to integrate health and social care commissioning within local authorities. In our view this will hasten the service improvements set out in *'Valuing People'*.

For People with a Mental Health Problem

2.5.7 We oppose the Government's plan to erode the rights of people who have a mental disorder in its new mental health legislation. The role of the Approved Social Worker in the current Mental Health Act provides the right safeguard in situations where compulsory treatment is under consideration. Our proposal for the integration of health and social care commissioning would help to progress the development agenda set out in the National Services Framework for Mental Health. Sadly we see little progress on the provision of education regarding mental health and in the reduction of stigma around mental illness. Liberal Democrats will make these a priority for action.

For People with a Physical Disability

2.5.8 Through our plans for integrated commissioning we will ensure that a close link is made between health and social care support services. The development of single equipment services should be a priority and steps taken to speed up assessment and

delivery of aids and adaptions. We will address the key issue of the national shortage of Occupational Therapists both through direct recruitment and by looking at ways of opening access to equipment services through other suitably trained staff.

2.6 Tackling Discrimination and Protecting Rights

2.6.1   A key theme for Liberal Democrats is tackling discrimination against disabled and vulnerable adults. Age discrimination legislation should go beyond employment and include the provision of goods and services by both the public and private sectors. We support the creation of a single Equality Commission and legislation to place a duty to promote equality on all public bodies. This would mean that the NHS and Social Services providers would be under a duty not to discriminate unjustifiably on the basis of age.

2.6.2   The legal position of vulnerable adults is in urgent need of reform. First, those vulnerable adults who live in private or charitable care homes are unable to enforce rights under the Human Rights Act. Following a ruling by the Court of Appeal the only way in which people can hope to secure their rights is for them to ask the local authority purchasing the placement on their behalf to enter into a contract which fully protected their rights. The current Government has refused to act to extend the protection of the Human Rights Act into private and charity run care settings. We would amend the Care Standards Act 2000 to incorporate human rights standards and statements on compliance as a pre-condition to registration by the Commission for Social Care Inspection (see Section 3).

2.6.3   Second, as the Law Commission concluded in 1995, "the law as it now stands is unsystematic and full of glaring gaps. It does not rest on clear or modern foundations of principle. It has failed to keep up with social and demographic changes (and) developments in our understanding of rights and needs of those with mental disability." In effect people deemed by others to lack capacity have no legal rights - they become non-people. This position leaves the most vulnerable, often elderly adults open to abuse.

2.6.4   The current 'all or nothing approach' whereby authority is passed to those claiming power of attorneys, or professionals giving healthcare and legal advice will no longer do. Common law does recognise that third parties must act in someone's 'best interest', but an incapacitated person's best interest is about more than 'managing' money or 'rationing' services to meet their care needs; it is about ensuring that they have a decent quality of life, that they can express their needs and emotions, and that they are treated with respect as autonomous individuals.

2.6.5   The government has shied away from reform in this area, despite promises of legislation year after year; the rights to life, privacy and family under the Human Rights Act must be given real form.

2.6.6   Our approach is for fundamental reform to give all those currently assessed as lacking capacity, new rights to maximise their own preferences on how their day-to-day lives should experienced and managed, and to radically redefine the way in which incapacity is treated in law.

2.6.7   We also propose reform of the Court of Protection to extend its jurisdiction. This should be a key plank of new legislation, too often relatives and carers find themselves in a legal maze when one of their loved ones ceases to be able to care for themselves. Powers of Attorney should be extended to cover health, welfare and financial issues - to take effect after registration and regulated through the Court of Protection's jurisdiction and that there should be tighter regulation

of informal mechanisms of surrogacy such as appointeeships which are all too often open to abuse. Consumer rights should also be protected; it is unreasonable to expect adults lacking capacity to fulfil all their contractual obligations, yet the policy of the Courts is that contracts should always be honoured, especially if they supply the necessities of everyday life. These rules need to be revised, and we will look also at the scope for placing legal duties on financial institutions in their dealings with vulnerable clients and consumers, so that they too will be expected to act in vulnerable adults' best interests.

2.6.8   Every child deserves to have their rights protected and promoted. The Government should legislate to incorporate the UN Convention on the Rights of the Child into domestic law and establish an independent Children's Commissioner. The task of a Children's Commissioner would be to promote and protect the welfare and rights of all children. A Commissioner would oversee all inquiries into and reviews of child deaths, monitor legislation and advise on new legislation. He or she would monitor and comment on the practice of public agencies.

Protecting Vulnerable People

3.1 The Current System

3.1.1 In 2000 the government launched *No Secrets* the interagency guidance for Police, Health and Social Services working with all the private and voluntary providers in the Care sector. The government defined six main types of abuse, physical, sexual, psychological, financial, neglect and discriminatory abuse. Social Services were given the lead and coordinating role which included responsibility for bringing all the local agencies together to promote effective inter-agency working, the identification of abuse, assessment of risk and whether abuse has taken place, responding to help those who are abused and the prevention of abuse. Unfortunately, government did not allocate any additional resources to take on these important and new responsibilities.

3.1.2 Since 1997 there have been a number of developments and additions to the systems for protecting the vulnerable, including the Criminal Record Bureau (CRB), the General Social Care Council (GSCC), and the National Care Standards Commission (NCSC). The Department of Health has also issued guidance on child protection, *Quality Protects*.

3.1.3 The CRB has proved to be a poorly planned and executed system which has been unable to cope with the level of demand for criminal record checks since it commenced operation in April 2002. In order to 'manage' demand the Home Office and Department of Health decided to postpone indefinitely checks on 300,000 domiciliary staff and agency nursing staff. Plans to implement the Protection of Vulnerable Adult (PoVA) List have also been postponed indefinitely.

3.1.4 The GSCC issues codes of conduct for social care workers and from 1st April 2003 it will begin to register social care workers starting with the estimated 80,000 qualified social workers and then moving onto qualified care home managers. Once a professional group are registered with the Council title will be protected and a person found to be in breach of the relevant code could be struck-off the register. There are estimated to be 1.2 million people in the social care workforce. The GSCC will register 60,000 a year. At that rate of progress it will take until 2023 to register the entire workforce. This is plainly unacceptable and the registration process must be accelerated.

3.1.5 The NCSC inspects care providers against nationally set minimum standards. There have been concerns about the lack of consistency in the application of regulations by inspectors. We would expect the NCSC's successor to ensure that there is a consistency of approach by all of its inspectors. The NCSC and Social Services Inspectorate are to be merged into a single new body known as the Commission for Social Care Inspection (CSCI). The inspection and audit of all health care will be undertaken by the Commission for Healthcare Audit and Inspection (CHAI). We have serious concerns about the 'independence' of the two commissions and believe that they should be at least as independent of Government as the National Audit Office. Liberal Democrats have long argued that seamless services need a seamless system of regulation and inspection which covers both health and social care. We welcome the intention to co-locate the new inspection bodies, but believe that their integration into a single Commission for Care Standards and Inspection must be the end objective. We would also abandon the arbitrary and meaningless 'star rating' systems for social services and health. In its place we would require the commission to decide for itself how best to ensure the public can make informed comparisons of performance in the delivery of health and social care.

3.2 Protecting Vulnerable Adults

3.2.1   The true scale of abuse of vulnerable adults is unknown. The Government has failed to undertaken systematic research to gauge the level of abuse. The Department of Health should commission research along similar lines to the US sentinel research programme to establish a clear baseline figure for abuse.

3.2.2   Action on Elder Abuse define abuse as 'a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person'.

3.2.3   One form of abuse is the inappropriate use of restraints. Examples of restraint include inappropriate or over medication, removing a persons walking aid, setting a heavy table in front of a residents chair to stop them getting up, tightly tucking in blankets, all of which can immobilise a resident as effectively as straps. Such abuse creates barriers between the residents and staff taking care of them and undermining residents' confidence and autonomy. It emphasises the power of staff and the powerlessness of residents promoting incontinence and dependency.

3.2.4   A succession of studies both in the UK and abroad, have demonstrated that the levels of prescribing far exceed the numbers of elderly people exhibiting conditions that are treatable by the drugs. Particularly at risk are elderly people with dementia. Managing challenging behaviour without trained staff is no excuse for reliance on chemical solutions. International evidence suggests that the annual reviews of prescribing to older people proposed in the National Service Framework for Older People are inadequate, and that harm can be done to an older person in far less time than a year.

3.2.5   The CSCI will have a clear statutory duty to safeguard and promote the welfare of children and a statutory office of Children's Rights Director to see the duty is acted on. However, there is no equivalent duty or office for vulnerable adults. This deliberate omission should be put right with the creation of the office of Vulnerable Adults Rights Director and the placing of a clear duty to safeguard and promote the welfare of vulnerable adults on both CSCI and the Commission for Health Audit and Inspection (CHAI).

3.2.6   Research has found that implementation of the *No Secrets* guidance is patchy. Few local authorities have drawn up service development plans to ensure that support services are put in place to prevent abuse and help the abused. Most local authorities have yet to include in contracts with service providers a requirement that their policies for the protection of vulnerable are adhered to.

3.2.7   In developing services to prevent, detect and counter abuse the well being of the vulnerable person must be paramount. Work with vulnerable adults who are at risk of abuse is a highly sensitive, highly skilful and highly demanding role for professionals. Specialist skills are required from health professionals, police officers and social services staff to identify abuse (when it happens), to make a full assessment, to respond to help the victims and to seek to ensure that abuse does not re-occur. As this is a developing area of care-practice the work in both responding to abuse and preventing abuse will require investment of new care resources. This must include significant training resources for all direct care staff who work with vulnerable adults. Liberal Democrats will ensure that the staffing, training, and support for effective interagency work and research resources are properly assessed and allocated by central government.

3.2.8   While our aim must be to prevent abuse, we must ensure that the victims of abuse have clear legal redress. Currently there is no specific statutory tort or offence covering neglect or abuse of a vulnerable adult. We would consult on the best way to close this loophole.

3.3   Protecting Vulnerable Children

3.3.1   Too many of the children who lose their lives through abuse or neglect or lead lives marred by abuse or neglect did not register on the child protection radar. Everyone, not just the state, has a responsibility to protect children. For public agencies, protecting children should be a key responsibility. All staff who have regular contact with the public, such as council and NHS receptionists, leisure centre staff and library staff should have child protection training.

3.3.2   No policy on protecting children can ignore the findings and recommendations of the Laming Inquiry into the death of Victoria Climbie. The report documents unacceptable failings of front-line practice and fatal flaws in the senior management of the local authorities concerned. The principal reason why Victoria Climbie was murdered is that too many of those with responsibility did not do their job. As Laming says Victoria would have been protected if nothing more than basic good practice had been put into operation. She did not require a new system as much as she required the performance of basic duties by those who saw her. So further training for staff must be an issue, as is the quality of some who are working in the care system, the pressure under which they work, poor conditions and remuneration.

3.3.3   Adequate financing would of course take us at least some way to a solution. Laming does refer to the Standard Spending Assessment (SSA), now Funding Formula Spending (FFS), by which Local Authorities are provided with funding for their Social Services Departments. Brent and Haringey both spent less on their children's service than was assessed as necessary by central government. We have considered ring fencing but reject this as it limits local discretion. Instead we would ensure greater transparency and accountability through the work of CSCI. Funding Formula Spending in itself only refers to the way in which money is divided rather than an objective measure of what would be required to provide a quality service.

3.3.4   Going beyond these basic issues, it is often the combination of different pieces of information, which when viewed together can confirm a suspicion and trigger a response. As the Laming Inquiry demonstrated, failure to integrate information meant that opportunities to safeguard Victoria were missed. The way in which information is collected, interpreted, shared and acted upon is fundamental to building a robust system for safeguarding children.

3.3.5   Arrangements for co-ordinating and planning child protection at a local level need strengthening. Area Child Protection Committees (ACPCs) must be put on a statutory footing and subject to regular joint inspection. All of the participating agencies should have a legal duty to participate in the work of the ACPC. The key tasks of the ACPC should be setting standards and performance targets for identifying and reducing the incidence of abuse, co-ordinating, monitoring and evaluating practice, ensuring learning from good and bad practice and gathering and reporting on met and unmet need.

3.3.6   The ACPC would contribute to local strategic planning and commissioning by highlighting priorities for service development. The Chair of the ACPC would have a statutory duty to report directly to

councillors any concerns about the ability of local agencies to contribute to child protection work.

3.3.7 The establishment of the post of Children's Rights Director within the NCSC has meant a clear focus on the needs of vulnerable children who are in care. But the writ of the Director is strictly limited to services regulated by the NCSC and is not a substitute for a Children's Commissioner. The creation of CSCI should mean that the Director will cover all aspects of children and family services. However, the Director's role should be extended to include services regulated by CHAI.

3.3.8 We welcome the recent creation of a Minister for Children in the DfES with responsibility for children policy across government (with the exception of children's health which remains at the Department of Health). However, this post does not obviate the need for an independent Children's Commissioner, and there remains a concern over how the transition from childhood to adulthood is dealt with in policy terms given that vulnerable adults are dealt with in DoH.

3.3.9 Home Office figures show that the number of child homicides has not fallen for thirty years. We have cut child deaths on our roads and reduced the risk of disease and illness in children, but the child death rates as a result of neglect and abuse have remained unchanged.

3.3.10 Framing effective policy requires information, but there is a disturbing lack of information on the causes and circumstances of unexpected or suspicious child deaths. The UN Committee on the Rights of the Child in its most recent report expressed concern that there is no systematic follow-up for child deaths in this country. There is no permanent database of child death cases. The full extent of child death in this country remains largely hidden. The UN Committee expressed its alarm at the lack of a co-ordinated strategy to reduce child deaths. To take such a

strategy forward we will establish a system of statutory child death inquiries, and include in future British crime surveys all crimes committed against children. These reviews will be overseen by the Children's Commissioner.

3.3.11 If a child is to be permanently removed from their family, a court considers the issue. A delay in making and then implementing that decision impacts on the development of the child. Research shows that a child's primary attachments are made between the ages of 18 months and three years, and that the older the child the less likely they are to attract interest from an adoptive family. And yet court proceedings are slow. The Children Act envisaged proceedings lasting a few months. They routinely last 18 months and longer. By the time an adoptive placement is found, the whole process could have taken two to three years. Reasons for delay include time to taken to instruct expert witnesses and lack of court availability. We would require the Department of Constitutional Affairs to take the lead in drawing up an action plan with the aim of cutting down these delays. As part of this plan, we would envisage laying down strict criteria to be met before experts are appointed, and maximising the amount of work that can be done before getting into court, for example through enforced parties' conferences. Specialist resources to provide assessments about prospects of rehabilitation might also assist, and could be delivered by consortia of Local Authorities.

3.3.12 One way of helping to implement quickly decisions to remove a child is 'parallel planning'. There are pilot schemes such as the Coram Concurrent Planning Project which use families who are 'matched' to a specific child but who initially are asked to foster the child while enquiries are made of the suitability of the birth family. If rehabilitation is not possible then the caring family are then able to adopt the child.

Governance, Organisation and Resources

4.1 Local Democratic Control of Health and Social Care

4.1.1   The Liberal Democrat vision of social care is much more than the fire fighting that Social Services Departments engage in today. If the people centred approach outlined in 1.1 is to be realised it requires a 'whole society approach' which fosters and supports communities in which individuals with care needs can best live independently. Local Government has a crucial community leadership role to play in promoting the health and well being of those who live and work in an area. This role would be strengthened by our plans to give local authorities a power of general competence, introduce a more representative and fair electoral system and greater financial autonomy from Whitehall set out in Policy Paper 30 *Re-Inventing Local Government* (1999).

4.1.2   Building on the work Councils are already undertaking in preparing local Community Plans we would require the health and social care impact of the plan to be assessed. We would expect Councils to use their community planning process to ensure that health and well-being promoting actions were integral to the work of the local authority and other local agencies. The economic regeneration function of local authorities will also be crucial in building the kind of cohesive communities which will offer a setting in which those with care needs can live independently. Land use planning can be employed to promote accessibility of vital services and ensure the design of the overall physical environment is conducive to independent living for those with disabilities.

4.1.3   A significant institutional barrier to this kind of integrated working is the false division between health and other local services which come under Local Authority control. We therefore propose to transfer the commissioning role of Primary Care Trusts to elected Local Government at the same tier as social services. The radical change of running these services through a pooled budget at this level will end the artificial division between clients identified to have 'Health' rather than 'Social' care needs, facilitating a 'seamless service' and more rapid progress on the comprehensive introduction of a single assessment process for clients.

4.1.4   The transfer of health commissioning functions to local authorities will allow a transition to a democratically accountable process with the minimum of further structural upheaval within the NHS. It will facilitate the further necessary process of devolution of decision making to the most appropriate local level. Devolution within some geographically dispersed and diverse authorities (such as County Councils) may mean there are several area committees controlling the Health and Social Care budget. There is a need to radically strengthen involvement of clients, carers and voluntary organisations within the new commissioning arrangements. The establishment of care forums with representation from all stakeholder groups would be one way of ensuring the views of a wide cross-section of those with specialist knowledge and expertise could be utilised. We would review and strengthen statutory rights of consultation on existing services as well as detailed involvement with regard to any new developments.

4.1.5   Giving political accountability over health commissioning to local authorities does not of course mean that councillors will directly take decisions on the medical care of individuals, any more than the existing political accountability of Social Services Departments means that councillors directly

take decisions over individual child protection issues. Professional decisions will remain for professionals. We believe that the existing culture of local government is in general more sensitive to dealing with voluntary and user groups, and this will be a positive influence on the culture of the health service in a more integrated system. It is also likely that greater integration of commissioning may lead to more rational resources allocation, for example as between primary and secondary care.

4.1.6   The Government has recently proposed piloting Children's Trusts to jointly commission health and social care services for children. We welcome this as a way to promote integrated care in the short term. However, ultimately Children's Trusts should be embraced within the wider programme of integrated health and social care commissioning we advocate through local government.

4.1.7   The case for the integration of health and social service commissioning holds true at a regional, as well as a local, level. Local services are at the heart of community and primary care; but local services cannot provide for the whole range of specialist health and social care needs. Local authorities would not provide every service locally, but make arrangements whereby each one can be provided appropriately, which may include purchasing services at some distance. Just as some specialist medical services need to be provided across a wide geographical area and over a larger population, more specialist social care, such as some types of long stay specialist accomodation or specialist needs education, should be commissioned regionally. As part of our programme for Regional Devolution in England, we would establish Regional Health and Social Services Authorities drawing together those functions of Strategic Health Authorities not devolved to local government and those functions of the Whitehall Department of Health which can be regionalised. The RHSSA would be under the democratic control of elected Regional Governments where the populations of those Regions so chose in a referendum. Until elected Regional Government comes into being we would establish RHSSAs as joint boards comprising councillors appointed by each local authority in the region. RHSSAs would also provide an excellent forum for cross-district information exchange and joint planning.

4.1.8   Such radical decentralisation does not mean that there is no place for agreed national minimum standards and a system of independent audit and inspection to ensure that they are met. Our plans for strengthening and integrating the inspection functions of CHAI and CSCI are detailed in section 3.1.5. The setting of national minimum standards for services should be faciliated by Central Government but agreed by local and regional government (as proposed in Policy Paper 53 *Quality, Innovation, Choice*).

4.2   Resources

4.2.1   Clearly the resource squeeze on social services has been acute, with many council Social Services Departments overspent on budgets. Reforms to the way services are commissioned and delivered along the lines we have advocated can achieve improved value for money. For example, it was recently discovered in Cheadle that local health, education and social services departments were all providing services for Autism sufferers, but without any co-ordination or knowledge of what the others were doing. Greater integration of services will allow more rational use of resources and the elimination of duplication. However, given the scale of the problem efficiency savings alone are unlikely to provide a complete solution.

4.2.2   Our proposed changes to local government finance with the abolition of the unfair system of Council Tax and its replacement by Local Income Tax, with rate

varying powers for local and regional government, and the return of local control over business rates, will strengthen local tax bases and allow authorities to alter expenditure in line with local needs and voter preferences. The council tax collection system costs around half a billion pounds a year across English local government, and scrapping it will allow us plough back the savings into local services. The reduction in the massive bureaucracy which has grown up in the current Health and Social Care organisations to negotiate the division between them will also free up resources within the unified budget for additional front line services.

4.2.3   A further way to make additional funds available for social care is by reallocating money set aside by the Department of Health to pay for the Labour Government's "bed-blocking fines". Instead of effectively taking this money from the NHS budget and putting it on one side, we would direct it straight to local authorities to pay for investment in capacity improvement such as intermediate care.

4.2.4   However, in addition to these measures we think the whole issue of social care funding needs a comprehensive review. We would therefore initiate an exercise equivalent to the Wanless review of health service funding (as Wanless himself recommended). This would include in its remit how public policy can help to achieve 'compression of morbidity' (a reduction in the length of the period of poor and deteriorating health most people experience towards the end of life).

4.3   Charges for Social Care

4.3.1   Liberal Democrats are committed to implementing the Majority Report of the Sutherland Royal Commission, including funding personal care costs for those needing long term care (subject to a needs assessment). This commitment would be funded from progressive taxation. Liberal Democrats have already delivered on this policy in government in Scotland.

4.3.2   Local authorities in England currently raise around £215 million per year from charges for non-residential care services. Although councils have discretion in charging, in practice most Councils charge for the majority of non-residential care services to balance their books. However, charges can deter access, create the need for collection arrangements which in themselves have costs, and overall raise relatively little in comparison with the total level of social care budgets. While our proposals for abolishing charges for personal care would go someway to ending non-residential charges there would still be charges for such things as domestic help. We would like to be in a position to abolish them, we believe that the future of such charges should be considered in the 'Wanless' - type review of social care funding proposed in 4.2 above.

4.3.3   There is mounting evidence from inquiries by the Health Service Ombudsman that local authorities are means testing and charging people when the NHS should meet the full cost of the person's care. The judgment of the Court of Appeal in the 1999 *Coughlan* case ruled that where a person's primary need for accommodation is a health need, then the patient's care funding is the responsibility of the NHS and not the local authority. The Department of Health has failed to provide clear guidance to the NHS on its legal duties. We would establish an independent case review and compensation scheme and ensure that clear guidance was issued and complied with.

4.4   Staff Training, Recruitment and Retention

4.4.1   There are some 1.2 million people in the social care workforce. Most of the

workforce is in the private and voluntary sectors. For example Social Services Departments do not employ 60% of qualified social workers. Recruitment and retention are serious issues right across the workforce. The delivery of the agenda mapped out in this policy paper hinges on the quality and commitment of that workforce.

4.4.2   There is little systematic collection of workforce information. What is known from survey work by the Local Government Association (LGA) is that nearly two thirds of Social Services Departments have difficulty in recruiting social workers and almost half cannot find enough home care staff. There are critical shortages of child protection staff. The position is particularly severe in London and the South East.

4.4.3   The King's Fund Report *Future Imperfect?* reported similar recruitment difficulties across the public, voluntary and private sectors. The recruitment difficulties were having a direct effect on the quality and cost of services as employers become increasingly dependent on agency staff. Low pay, low status and competition for social care staff has led to concerns that care providers have little choice but to fill vacancies with people with high numeracy and literary training needs.

4.4.4   It is clear that low pay is a significant factor in the recruitment and status problem. The local government finance reforms indicated above and the additional scope for extra pay allowances in high cost areas supported in *Quality, Innovation, Choice* will allow a start to be made on tackling this problem.

4.4.5   The LGA Report *Care to Stay?* also identifies a link between management and staff shortages. Where there has been a lack of effective planning this has led to a cycle of heavy workloads, low morale, long hours and high staff turnover. What is required is a human resources strategy and co-ordinated approach to workforce planning across health

and social care. It will aim to raise standards, boost morale and status, draw talent into social care and enable more rational and effective planning and management. This strategy will need to have both a national component and scope for adaptation to meet local needs.

4.4.6   The human resources strategy will have to establish a three-year or equivalent professional qualification as the basis for a professional career in personal social services. It will require appropriate management training to develop the necessary skills in those with management responsibilities. A clear career path within social care will have to be mapped out which both has routes into management and scope for senior practitioner status for those who wish to develop their careers while still working directly with clients. Combining these changes with a strong public information campaign to publicise the importance and emotional rewards of social work should both boost status and help solve recruitment and retention problems.

4.4.7   The strategy should also encourage entry to social care work from a diverse range of people. Social care could be made an attractive 'second career' option for those returning to work after a long period devoted to family responsibilities. Greater encouragement should be given to those with physical or learning disabilities to work within the social care setting.

4.4.8   It will also have to ensure that providers are supported in developing their staff. In key shortage areas the strategy could target resources for the development of home-grown staff and special remunerative measures to attract and retain staff. The homegrown scheme would enable social care employers to select and support appropriate and suitable known staff in obtaining qualified status. This would be delivered by inhouse schemes accredited by local suitable academic institutions. Such schemes could attract those who would not have gone on to

traditional social work training. We should also be encouraging greater freedom of movement between 'health' care, 'social' care, and other types of hands-on care roles. Developing NVQ training jointly with health partners would help to develop transferable skills.

4.4.9   The human resources strategy would also address the need to develop common training of all staff involved in child protection work. This would form part of a wider drive to develop the ethos and practice of multi-agency working in the delivery of health, housing and social care.

4.4.10   An important feature of workforce planning will be ensuring qualified social workers are able to concentrate on the professional work they are trained for and do not get bogged down in routine administration and paperwork. Intelligent use of IT systems should be promoted to ensure time spent on necessary administrative tasks is kept to a minimum.

4.4.11   At a national level the twin aims of reassuring the public that the needs of vulnerable children and adults are being properly safeguarded and that the status of all social care workers is being raised can be advanced by accelerating the registration programme of the GSCC.

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