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The Personal Social Services

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The role of the public sector is essentially to ensure that care is provided. How it is provided is an important but secondary consideration and local authorities must show that they are getting and providing real value.

So said Sir Roy Griffiths in his report to the Secretary of State entitled *Community Care: Agenda for Action*.¹ This brief quotation encapsulates the degree and nature of the change which faces local authorities in general and social services departments in particular. If the period 1946-8 saw the introduction of the legislative framework for modern day services, and 1968-71 saw the Seebohm Report and the development of the personal social services, it is likely that 1989 – the centenary year of County Councils – witnessed a shift in both philosophy and practice away from the almost monopoly provision of services toward a ‘market-place’ approach.

The development of social services

The legislation in the mid-1940s was stimulated by widespread disillusionment with the fragmented approach of the Poor Law and even greater disenchantment about the process of charitable help which operated on an eligibility test and which, whether intended or not, often humiliated people in the process. The role of the state in the provision of welfare services in post-war Britain was seen by many as a move away from a system of charity towards the provision of services as a right based upon the assessment of need, irrespective of wealth, creed or colour. It sought to treat all people equally and to remove stigma. Within it was the concept of a redistribution of wealth as an expression of the concern of the community for each of its members. The

idea was that the strong helped the weak, the healthy provided for those who were ill and the able helped those with disabilities or handicaps.

In reality the demand or need for services far outstripped the resources and, over the years, the considerable achievements of the services were often overshadowed by their alleged failures. So it was that the number of patients successfully treated by the health service rarely received the same public attention as the size of waiting lists. The strengths of the services, such as the right of everyone to consult a medical practitioner at will and, when appropriate, to be linked to a whole series of specialisms, or to have a home help or meals on wheels, never received the same attention as the lack of choice or competition and the failure to cope with rising demands. The remarkable framework of services in Britain, so easily accessible to all, was frequently compared with the centres of excellence in other countries without regard to the fact that those centres might be accessible to only a very limited section of the population.

Indeed, the expectation that services would be available to all, at all times, had within it the seeds of failure as the standards set became incapable of realisation. All systems have to ration access to services, and in other countries it is often achieved by the individual's ability to pay. The general feeling that services were not achieving the standards expected of them either in quality or in quantity was exacerbated by a growing belief in some quarters that all social problems were the responsibility of the state and that 'they should do something about it'. For a time the state services almost became isolated from the public who owned them and whom they served. The part which could and should be played by others was often minimised at the very time that it ought to have been accentuated and developed.

Changing patterns of demand

Because of improved medical and social care people with severe physical disabilities, often multiple in nature, and those with mental handicaps or severe learning problems, survived to a life expectancy not dissimilar from that of other members of the population. As a result, the numbers needing intensive care increased greatly. At the same time the philosophy of 'care in the community' gathered pace and with it the expectation that services would be provided which would enable people with severe difficulties to remain in their own domestic surroundings.

Demographic changes brought about a large increase in the over seventy-five-year-old age group. From this followed new demands for care and support to older people in their own homes, not only in respect of increased physical frailty and incontinence but also in the support of people suffering from severe mental confusion. The closure of large psychiatric hospitals and

the replacement of these services by small units in District General Hospitals again resulted in the vast majority of care being provided in the home by local domiciliary and community-based services. These changes took the community-based services into hitherto uncharted waters. They were faced with not just the increase in demand and the greater expectations of users of services and their carers, but also the need to cope with much greater levels of disability, confusion and incontinence in ordinary domestic surroundings.

The large institutions built with such enthusiasm by the Victorians for the poor, the old, the mentally ill, the handicapped, and orphans and other children in need of care were to be replaced by preventative services and community-based support systems aimed at helping people remain as independent as possible, and with dignity and a sense of well-being. Whatever may be said now about Victorian values, the fact is that in those days it was the norm to 'put away' those members of society who could not care for themselves. This process lasted a hundred years and more, yet within a short period an attempt was made to reverse the trend and to create a new norm by introducing policies based upon 'integration' and 'normalisation'.

This would have been an extremely difficult task in itself, not only in providing new services of a different style but also in helping local communities accept into their midst people with unfamiliar behaviour patterns who would arouse feelings of concern, uncertainty and fear. It was made all the more hazardous by the fact that other changes were taking place in family life resulting in smaller family units made much more complex in character by, amongst other things, divorce and co-habitation outside marriage.

Of immense importance in all this is the greater freedom now accorded to women to use their talents to the wider well-being of society by becoming economically active. We are still a long way from realising equal opportunities for women and other groups and, if they are to succeed, the needs of carers must be fully addressed. This is all the more important because, while society has developed the means of keeping alive more people with much greater dependency needs, it has yet to devise systems to support them in the community without making unrelenting demands upon individual carers.

Nor can a policy of care in the community succeed without proper regard being given to the incidence of geographic mobility. Changes in patterns of employment and ease of travel make geographic mobility in the population much more common than in times past. Far fewer people now live their lives in or near the place of their birth surrounded by a network of relatives and close friends. No matter how caring families are, it is in reality difficult to provide day-by-day support from a distance.

Towards care in the community

It is against this background of massive change in theory and practice that the Audit Commission concluded in their study *Making a Reality of Community Care* that successive governments have pursued ambitious policies without ensuring that the finance and the systems were in place to make these policies both effective and reliable in practice.² The report by Sir Roy Griffiths was published just after a major report on residential care by a working party chaired by Lady Wagner entitled *Residential Care – A Positive Choice*³ and after yet another report on an inquiry into the death of a child in care – Jasmine Beckford.⁴ It was followed by the report by Lord Justice Butler-Sloss into alleged sexual abuse of children in Cleveland.⁵

The desk of the Secretary of State is now weighed down with reports containing numerous recommendations of immense importance about ways in which our society might better meet the needs of those who need personal care, support or control. The reports offer no easy solutions to what are social issues of supreme importance. In some instances they may appear to contradict each other because of a difference of emphasis.

For example, the report into the death of Jasmine Beckford criticised social workers, health visitors, magistrates and others for not focusing clearly enough on the welfare of the child and putting too much trust in statements made by her parents. The Cleveland Report, on the other hand, criticised doctors, social workers, police, magistrates and others for not paying sufficient regard to parents. The wish to respect the rights of parents to bring up their children according to their own values and beliefs cannot always be reconciled with the wish to protect children and, in particular, to ensure that any suggestion of alleged abuse is fully investigated in ways which neither undermine parents nor add to the pain of the children. The government's failure to introduce family courts in the recent Children's Bill will not assist this process.

In looking to the future it is safe to make at least one prediction, namely that the issues of care in the community will assume greater importance and will attract more publicity and be ever more hotly contested. As the Audit Commission report concludes, 'What is not tenable is to do nothing about the present financial, organisational and staffing arrangements'. The issues will simply not go away. Whatever the system of the future, it needs to build upon the strengths of the current services: ease of access, service according to assessed need, the avoidance of stigma and the spread of facilities throughout society. What must be avoided is a return to the fragmentation of the past, a 'two-tier' system separating the 'haves' from the 'have nots', with the public sector becoming a residual service.

The role of the local authority

It is one of the strengths of an open society that power is distributed from the centre and that local communities are enabled not only to identify their own needs but also to call into operation any resources which they may possess. If community care is to succeed in practice it will depend upon the active support of local people and local organisations. County Councils serve communities which are immensely varied. It is one of their great strengths that they are sufficiently large to develop a strategic plan for a wide area and large populations and yet at the same time so organise their services that they are easily accessible to local communities.

The changing pattern of employment, particularly with the decline of the older heavy industries and the growth of high technology and service organisations, has necessitated strategic planning of housing, transport, education, employment and a range of services so as to ensure a good environment in which families can live, work and enjoy their leisure. But the style of service delivery needs to be related to the peculiarities of the community being served. For example, the opportunities in a relatively affluent, well established market town may be quite different from those in a new town or a vast housing estate in which a high proportion of residents commute to a nearby city. County Councils have demonstrated an ability to work with local communities, linking with voluntary organisations and self-help groups in order to respond to local needs.

From time to time consideration has been given to the creation of Regional Councils or the greater devolution of services to District Councils. In practice the former may be too large and remote and the latter may be too small to sustain the necessary range of specialist services which are increasingly needed to cope with the much greater degrees of disabilities now evident as care in the community gathers momentum.

The size of County Councils has also facilitated the gathering of information about the possible effects of government plans on people, whether they live in cities, urban areas, small towns or rural communities. The interface between central and local government is of great importance, and proposed changes in legislation and policies should be informed by good reliable information to avoid an undesirable impact. Evidence produced by County Councils and marshalled and presented by the Association of County Councils has done much to ensure that successive governments have tempered proposed changes so as to ensure that many unintended consequences were avoided.

It is, of course, not just the contact with central government which is important. It is equally important that social services departments should have good links with the health authority, the housing department and the education

and probation services. County Councils have, for the most part, established common boundaries with these organisations and once again they have been able to demonstrate that they have been large enough to develop joint planning committees. They have also established highly specialist services, meeting the needs of people with particular disabilities or learning problems. The ability to develop both general and specialist services is an organisational strength which should not lightly be put at risk.

The centre of this process is the local authority. No other body can fulfil this role without running the danger of becoming remote and inflexible. It is important to note that in 1984 the then Secretary of State for Social Services, Norman Fowler, said:

Three paramount responsibilities are laid on any Social Services Department: first to take a comprehensive strategic view of all of the sources of care available in its area; second to recognise that the direct provision of services is only part of the local pattern...; third to see a major part of its function as promoting and supporting the fullest possible participation of the other different sources of care that exist or which can be called into being. That view was fully endorsed by Sir Roy Griffiths who made plain his belief that the local authorities should be at the centre of the process in the translation of community care from 'theory' to practice. The well-being, care and dignity of a growing part of the population, who for one reason or another depend upon help and support, hang on the response of the government to this issue.

In November 1989 the long awaited response by the Government to the report by Sir Roy Griffiths was published in a White Paper entitled *Caring for People – Community Care in the Next Decade and Beyond*.⁶ Although the White Paper adopted many of the recommendations of the Griffiths Report, including the one giving local authorities the lead responsibility, it did not accept the recommendations with regard to the funding of services. The White Paper set out the following six key objectives which were

- (i) To promote the development of domiciliary, day care and respite care to enable people to live in their own homes wherever feasible and sensible.
- (ii) To ensure that service providers make practical support for carers a high priority.
- (iii) To make proper assessment of need and good case management the cornerstone of high quality care.
- (iv) To promote the development of a flourishing independent sector alongside good quality public services.
- (v) To clarify the responsibility of agencies and so make it easier to hold them to account for their performance.
- (vi) To secure better value for taxpayers' money by introducing a new funding structure for social care.

The White Paper was generally welcomed in principle and in particular the definition of community care, which stated that 'Community care means providing the right level of intervention and support to enable people to achieve maximum independence and control over their own lives'.

However, the funding of community care continued to be a controversial issue both within Parliament during the passage of the National Health Service and Community Care Bill and amongst voluntary organisations, private agencies and carers groups. In particular local authorities feared that they were going to be given the responsibility but without the certainty of funding.

This fear was reinforced when, on 18 July 1990, the Secretary of State made a statement to Parliament saying

Since I announced the Government's proposals (about community care) it has become overwhelmingly clear that many local authorities are not managing their services and their spending so that they deliver good quality services effectively within reasonable spending limits. In many cases local authorities have imposed excessive levels of community charge on their residents. In these circumstances it is only sensible that any new burdens on local government in 1991/92 be kept to an absolute minimum.

He went on to say that the plans for care in the community would be phased and that the major development which relates to the transfer of income support payments from the Department of Social Security to the local authorities, would be implemented from April 1993.

Local authorities will continue to be expected to develop community care plans, to set up an arm's length inspection unit and to set in place such matters as complaints procedures but the major change relating to assessment and case management will not now be implemented before the next General Election. The media concluded that this was not primarily motivated by concern about community care but more about the community charge and the financing of local authority services.

What is clear is that the issues surrounding the development of care in the community in this country cannot be willed away and, indeed, the problems now being experienced may well be a good deal worse when they come to be tackled in 1993. The struggle goes on.

References

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