Community care choice means radical change

Health professionals responsible for the care of clients in the community are finding their practice hampered by lack of high standard and flexible housing provision.

By Dina Leifer

WHEN THE policy of community care was launched in the early 1990s, the aim was to give people with health or social care needs the support to live as independently as possible.

The reality in the UK today is that many service users are being offered little or no choice as to where and how they can live. In many cases, the big institutions of the past have been swapped for smaller ones in the community.

Proper planning and provision of housing would go a long way towards solving this problem, according to High Hopes, a new report from the Joseph Rowntree Foundation.

"There is a gulf between the upbeat rhetoric of community care and the problems of housing policy," said the report’s author, Lynn Watson, at its launch in London last week.

The report draws together 21 research projects to form a picture of older people, people with disabilities and those with mental health problems trying to find their way through a system made up of health, housing and social services, and which expects them to fit in with whatever is available.

One house manager, in a report on services for people with learning disabilities, put it bluntly: "What’s choice got to do with it? If a suitable vacancy is available – right, you make the most of it. You go where they can take you."

An elderly woman speaking to another researcher said: 'I was offered no choice. I wanted a warden-controlled flat on the ground floor with access for an electrically-powered chair as I am disabled, but I was taken to this residential home and I was not told why my request could not be met.'

People with mental health problems were finding the alternative to a hostel was often a flat which no one else wanted in a run-down estate. This sometimes made mental health problems worse and led to a chain of transfers. ‘Many respondents had had a succession of moves from unsatisfactory property to another and some saw the hospital ward or hostel, by contrast, as an asylum and a secure base,’ the report says.

Ms Watson found that community care assessments of older people leaving hospital, which were originally envisaged as a chance to help them achieve their potential, were seen by the clients as something which had to be ‘passed’ like a driving test.

Health professionals were sticking to rigid ideas of ‘safe discharge’, assessing what people could not do rather than what they could be helped to achieve, she said.

The assessments were based on what resources were available, not on what the client wanted.

One planning officer admitted: ‘If we assess someone and write down what she needs, it becomes a duty for us to provide. Because of that, people will put down what they can offer, but not what they cannot offer.’

Housing vulnerable people on run-down estates can often exacerbate their existing health problems.
Lynn Young, community health adviser for the RCN, said she recognised the situations described in the report. Nurses carrying out assessments were under stress because they knew they could not offer the facilities people needed, she said.

The picture was also familiar to Pauline Ford, the RCN's adviser on nursing older people. 'It has been recognised for some time now that community care is failing older people and it will continue to fail them until this is resolved,' she said.

'We have got a policy which is fiscally driven, not needs led. By and large, people will get the cheapest option for care provision. This means people will continue to be placed in residential and nursing homes, because the cost of the alternatives is too high and we don't have the flexibility to meet the needs.'

Lack of flexibility was also a problem in the types of community services offered to people.

Speaking at the report's launch, Julie Golding of the group Advocacy in Action described the case of a disabled woman who had a 'whole army' of people coming into her flat to look after her, even though she did not want many of them.

'Some providers need to reduce their dependency on the people they are providing for,' Ms Golding said.

Ms Watson said the present system's rigid distinction between housing and residential care was no longer relevant to the range of services which more imaginative agencies were providing.

The system also did not take into account services such as leisure and transport, which were not directly health-related, but which could reduce people's need for care services and allow them to live more independently.

'We have to look at the whole picture. We need a radical change of the housing system,' she said.

She called for a major national housing initiative, national guidance on the kinds of preventative support services and official encouragement for the setting up of advice and advocacy services.

The report's call for collaboration between agencies and departments echoes the approach of the government's strategy on public health, launched by public health minister Tess Dowell this week.

A health department spokesperson said: 'Ministers are looking for ways to improve communication between agencies and we will look at this report. One option being considered for better delivery of services is pooled budgets for health authorities and local authorities.'

### Moving the board

The new government obviously means business in its attempts to make trust boards more representative

By Adele Waters

'I WOULDN'T trust any children's lives in the hands of Labour and I wouldn't trust Labour with the lives of the children in this hospital.'

That warning at last year's Conservative Party conference came from the chair of Birmingham Children's Hospital NHS Trust, Patricia Marsh. It also lay behind her resignation last week. She said the controversy caused by the remark made it impossible for her to remain in post with a Labour government in power.

Her departure followed that of four of the eight most senior regional health chiefs in England last month, only one of whom resigned voluntarily. In its pledge for a more open, accountable and representative NHS, the government clearly means business.

Speaking at Unison health sector's annual conference last week, health secretary Frank Dobson said he wanted to change the type of people appointed to NHS boards: 'I want top quality people. I'm not interested in replacing Tory deadbeats with Labour ones.'

Mr Dobson said he wanted ordinary people appointed as non-executives to join trust boards in December, when scores of such appointments are due to be made. These would include NHS users, patients and carers - 'more of the sort of people I'd like to see fighting for me as a patient on my local trust board or health authority,' he said.

At present, nationally more than 70 per cent of trust board members are business or professional people, 8 per cent are from the voluntary sector and 3 per cent are from local government. But Mr Dobson said the balance of board membership must be changed, and last week he wrote to MPs and local councils asking them to nominate local people for membership. The selection criteria will be changed to ensure trust boards appoint carers, service users and community representatives, and definitely not those committed to private health care.

'The balance will be shifted towards NHS users and carers, and others with a community voice. Regional chairmen have been asked to assess all their recommendations against this criterion,' Mr Dobson said.

The application procedure for NHS board membership, which takes into account guidance from the Office of the Commissioner for Public Appointments, mirrors common recruitment practice.

Board level positions are advertised in the press and applicants are invited to send a CV and complete an application form. Candidates go through a selection process which involves independent assessment and a panel interview. But the new recommendations mean it is now considered 'essential' for non-executive board members to be available three days per month, live nearby, have a strong personal commitment to the NHS and possess plenty of common sense. Political activity does not preclude application.

These moves, plus the government's call for trust board meetings to be held in public, have been generally applauded. But some warn they may have limited success.

The NHS Confederation said: 'We are broadly in support of the recommendations. It is absolutely essential that board members have clear links with the NHS, a knowledge of local needs and a wide mix of skills and experience, as well as a good mix of social and ethnic backgrounds.'

Toby Harris, chair of the patient watchdog organisation the Association of Community Health Councils for England and Wales, said: 'It is important for trust board meetings to be held in public and for people making decisions to have clear links with their communities.'

He was doubtful about wiping out political bias. 'The reality is that when people talk about keeping politicians out of the NHS, they only want people to agree with them. All decisions have a political dimension.'

Chris Dabbs, adviser for the community health council in Salford, Greater Manchester, agreed: 'If you look at the political affiliations of health authority chairs, there would be a fair predominance of Conservatives. Now, are we just going to get the opposite of that?''

But Mr Dabbs said user-representation would mean nothing unless the culture of organisations changed. 'What does patient representation mean? Having one person on a board is not something we'd oppose, but it's very limited. The culture of the organisation is more important, and whether patients are involved at all levels. After all, you can be represented badly.'