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Health Committee

Social Care

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Volume II

Oral and written evidence

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom

Committee staff

The current staff of the Committee are Dr David Harrison (Clerk), David Turner (Committee Specialist), Lisa Hinton (Committee Specialist), Frances Allingham (Senior Committee Assistant), Julie Storey (Committee Assistant) and Gabrielle Henderson (Committee Support Assistant).

Contacts

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Witnesses

Thursday 29 October 2009

Mr David Behan, Director General of Social Care, Mr John Bolton, Director of Strategic Finance in Social Care, Local Government and Care Partnerships, Ms Alexandra Norrish, Head of Social Care Strategy, Department of Health and Mr Jeff Jerome, National Director for Social Care Transformation

Thursday 5 November 2009

Mr Raphael Wittenberg, Personal Social Services Research Unit, London School of Economics and Political Science, and Professor Carol Jagger, Professor of Epidemiology and Director of the Leicester Nuffield Research Unit, University of Leicester

Mr Richard Humphries, Senior Fellow in Social Care, The King’s Fund, Mr James Lloyd, Senior Research Fellow, Social Market Foundation, and Mr Donald Hirsch, independent consultant on social policy and Head of Income Studies in the Centre for Research in Social Policy, Loughborough University

Thursday 12 November 2009

Baroness Young of Old Scone, a Member of the House of Lords, Chair, and Mr Ronald Morton, Strategy Development and Innovations Manager, Care Quality Commission, and Mr Sampson Low, National Policy Officer, UNISON

Ms Lin Hinnigan, Director of Strategy, General Social Care Council, Mr Allan Bowman, Chair, Social Care Institute for Excellence, and Ms Andrea Rowe, Chief Executive, Skills for Care

Thursday 19 November 2009

Ms Sheila Scott OBE, Chief Executive, National Care Association, Mr Martin Green, Chief Executive, English Community Care Association, and Mr Colin Angel, Head of Policy and Communication, UK Homecare Association

Mr Chris Horlick, Managing Director of Care, Partnership Life Assurance Company Ltd, and Mr William Laing, Economist, Laing and Buisson
Thursday 26 November 2009

Mr Andrew Harrop, Acting Charity Director, Age Concern and Help the Aged, Mr Stephen Burke, Chief Executive, Counsel and Care, and Mr Andrew Chidgey, Head of Policy and Public Affairs, Alzheimer’s Society

Mr David Congdon, Head of Campaigns and Policy, Mencap, Ms Sophie Corlett, Director of External Relations, Mind, Mr Stuart Nixon, Vice Chair of the Board of Trustees, Multiple Sclerosis Society, and Ms Imelda Redmond, Chief Executive, Carers UK

Thursday 3 December 2009

Professor Caroline Glendinning, Professor of Social Policy, University of York, Professor Peter Beresford, Professor of Social Policy, Brunel University, and Mr John Waters, Technical Director, In Control

Ms Jenny Owen, President, Association of Directors of Adult Social Services, and Councillor Sir Jeremy Beecham, Vice-Chair, Local Government Association

Thursday 7 January 2010

Rt Hon Andy Burnham MP, Secretary of State for Health, and Mr David Behan, Director General of Social Care, Local Government and Care Partnerships, Department of Health, and Ms Hazel Hobbs, Joint Head of the Disability and Carers' Benefits Division, Department for Work and Pensions
List of written evidence

The following memoranda were published as Social Care: Written evidence, HC 1021, Session 2008–09

1. Department of Health
   Supplementary by DoH
2. Mencap
3. Sense
4. Medway Older People Communication Network
5. National Union of Journalists’ Pensioners Committee
6. Essex Independent Care Association
7. Royal College of Nursing
8. Mr Ashleah Dean Skinner
9. Local Government Association
10. Home Group Ltd
11. The Hesley Group
12. Nestor Healthcare plc
13. Sanofi Pasteur MSD
14. Association of Directors of Adult Social Services (ADASS)
15. Linda Pickard
16. A Dignified Revolution (ADR)
17. United Kingdom Homecare Association (UKHCA)
18. Parkinson’s Disease Society
19. Alzheimer’s Society
20. National Pensioners Convention
21. Bupa Group
22. Mind
23. The King’s Fund
24. UNISON
25. Care Quality Commission
26. Royal College of General Practitioners
27. Independent Age
28. The LIFT Council
29. Partnership Life Assurance Company Ltd
30. College of Occupational Therapists
31. Leonard Cheshire Disability
32. Mental Health Foundation
33. Sue Ryder Care
34. Macmillan Cancer Support
35. Age Concern and Help the Aged
36. The Princess Royal Trust for Carers
37. Counsel and Care
List of further written evidence

The following written submissions were received after the publication of Social Care: Written evidence, HC 1021, Session 2008–09.

1. Parkinson's Disease Society (SC 19A) Ev 167
2. Scope (SC 51) Ev 168
3. Universities of Essex and East Anglia (SC 52) Ev 172
4. Carol and Douglas Batchelor (SC 53) Ev 178
5. COMPAS (SC 54) Ev 179
6. MAP2030 Research Group (SC 55) Ev 181
7. Anchor Trust (SC 56) Ev 191
8. Circle Anglia (SC 57) Ev 194
10. Dementia Services Development Centre (SC 60) Ev 201
12. Department of Health (SC 01B) Ev 205

List of unprinted evidence

The following written evidence has been reported to the House, but has not been printed and a copy has been placed in the House of Commons Library, where it may be inspected by Members. Other copy is in the Parliamentary Archives (www.parliament.uk/archives), and is available to the public for inspection. Requests for inspection should be addressed to The Parliamentary Archives, Houses of Parliament, London SW1A 0PW (tel. 020 7219 3074; email archives@parliament.uk). Opening hours are from 9.30 am to 5.00 pm on Mondays to Fridays.

Alan Spence (Bury Place Residents Association) (SC 59)
Oral evidence

Taken before the Health Committee

on Thursday 29 October 2009

Members present
Mr Kevin Barron, in the Chair
Charlotte Atkins Mr Lee Scott
Mr Peter Bone Dr Howard Stoate
Sandra Gidley Mr Robert Syms
Stephen Hesford Dr Richard Taylor
Dr Doug Naysmith

Witnesses: Mr David Behan, Director General of Social Care, Mr John Bolton, Director of Strategic Finance in Social Care, Local Government and Care Partnerships, Ms Alexandra Norrish, Head of Social Care Strategy, Department of Health, and Mr Jeff Jerome, National Director for Social Care Transformation, gave evidence

Q1 Chairman: Good morning and welcome. Could I invite you all to what is our first evidence session on our inquiry into social care. I wonder if I could ask you, for the record, if you could give us your name and the current position that you hold?
Mr Jerome: I am Jeff Jerome; I am the National Director for Social Care Transformation working to the Local Government Consortium.
Mr Behan: My name is David Behan, I am the Director General of Social Care, Local Government and Care Partnerships in the Department of Health.
Mr Bolton: My name is John Bolton, I am the Strategic Finance Director working to David Behan.
Ms Norrish: I am Alexandra Norrish, Head of Social Care Strategy at the Department of Health, also working to David.

Q2 Chairman: Welcome. David, I have got a couple of questions for you to start this session. Could you summarise very briefly for us what adult social care is and how it is provided?
Mr Behan: Yes. Would it be helpful if I say something about what the agenda is for adult social care, just to set some of the context as well, Chairman?

Q3 Chairman: Yes. I am sure we are picking up many of the aspects of recent years, but if you can do that, that would be fine.
Mr Behan: We define in the Green Paper that social care are those services which are designed to support people’s independence, to help them maintain their lifestyle, to play a full part in society, to protect them in vulnerable situations and to manage those complex relationships and the emotional distress that they might experience as a consequence. So I want to emphasise, in a sense, the practical assistance that people get as well as that assistance with the emotional elements of day-to-day living. I would include in that definition help with personal care, a range of very practical other services—home care, day centres, residential care, nursing care, support to carers—but also the psycho-social aspects of that as well as the assistance provided to many people with disabilities to go into employment, to negotiate the complexities of the welfare system, such as housing and benefits, etcetera. Social care is directly commissioned by local authorities. We spend about £16 billion gross on social care each year in this country but, unlike the National Health Service, there are 152 top tier local authorities that are responsible for commissioning social care. They are responsible for commissioning those services locally within their communities, but there are over 30,000 separate providers of social care. Social care is a very pluralistic sector, it is a very mixed economy, with a majority of residential care and domiciliary care now being provided by the private and the voluntary sector, with local authorities, largely, although not exclusively, occupying a commissioning role. Very often that role will be discharged with health colleagues but also, importantly, at a local level, with housing colleagues. Issues around extra care housing, support to people with disabilities on independent living is likely also to be commissioned with housing colleagues at a local level.

Q4 Chairman: Thank you for that. Where do you think healthcare ends and social care begins? What do you think to the view that the distinction between the two is often described as arbitrary and inconsistent?
Mr Behan: The tradition is different. Arguably, the NHS when it was founded in 1948 was a settlement between individual citizens and the state about how health was to be provided. I personally would argue that the same settlement was not struck around social care, because some of the issues that we are dealing with today were just not as apparent in 1948. Life expectancy for a man was 66 in 1948—basically, you worked until you were 65, you had a year and you died—whereas now life expectancy for a man is well into the seventies, 77, and for a woman 82, and it is increasing year on year. There are issues around dementia. There was a programme on the Today Programme yesterday talking about the changing nature of Down’s Syndrome and the increasing
numbers of people with Down’s Syndrome. Not only is our population changing through demography, more of us are living longer. Healthy life expectancy is not keeping pace in the same way and, therefore, dependency in later years is one of the issues we are addressing in the Green Paper. Disability as we know it now, the advances in medical science by neonatologists, paediatricians, means that many severely disabled children who in previous years would have died are surviving through childhood into adulthood and, in many cases, into late adulthood. So what we need to do is strike a new settlement between individuals and the state in relation to social care, and that is what the Green Paper is about. In essence, the funding is different. The NHS is funded through general taxation, it is free at the point of need, it is a universal service and it is available to all, and it always has been since 1948. Social care, on the other hand, is funded through a combination of national and local taxation and means-tested contributions from individuals, and always has been since 1948. Interestingly, we did a MORI survey before we launched the Green Paper and over 48% of respondents felt that, if they needed care in later life, that care would be free at the point of delivery. It is a great illustration, in many respects, of the gap between people’s knowledge of how the care system operates and the reality of how it operates and the fact that that settlement has not been struck in the same way. So the funding, essentially, is different. There is not a National Health Service which has a management run by a chief executive for social care: there are 152 local authorities. They are responsible for setting their policies, interestingly, for setting the prices that they will charge and setting their charging regime—my earlier point about social care being pluralist. You come at this, however, not from the point of the institutions but from the point of people who are being assisted to live independently in the community and you look at the complexity of the issues that many people who are being supported by social care will be confronted by, and you will find that people have a range of needs, many of which will be healthcare needs sitting alongside conditions which require long-term support in the community. These are largely people with long-term conditions, for which there is not a cure, who will require ongoing support.

Q6 Chairman: We will be moving on to questions about that. What do you see as the greatest shortcomings in current social care policy, care provision?

Mr Behan: Increasingly, over the past years, what we have found is that the money that is spent through the public care system is being spent on a set number of people at a time when the demand for services is increasing. So eligibility criteria have been introduced which actually set priorities which determine which people will be publicly supported by the care system and which people will not. The consequence of that is that there are people who could be supported who are not being supported at the present time. So one of the key issues we have had to deal with is those people who have high needs who are not getting access to the care and support system at the present time, and the Green Paper is an attempt to address that deficit. The consequence of that is that the informal care system will often have to do a lot of the heavy lifting of care, providing that day-to-day care as a consequence. So the Carers Strategy was designed to help to continue to support carers, to enable informal carers, unpaid carers to continue to provide that care, but the balance between the formal care system and the informal care system has changed over recent years. So the shortcoming, to answer your question, Chairman, is the fact that people who might be better supported in the formal care system are no longer supported in the formal care system and we need to ensure that we are actually spreading the way that the care system operates: so putting people first on policies about intervening at an early stage to maintain people in their independence. Arguably the current system intervenes at too late a stage, when problems have become acute and chronic, and not at an early enough stage to prevent those problems becoming acute and chronic. So we need to rebalance the system, and that is what Putting People First and the Green Paper is attempting to do.

Q7 Chairman: Do you think the current shortcomings (and there are some in the system) are down to the under funding and the way that social care is funded? Is it that, do you think?

Mr Behan: The Green Paper acknowledges that one of the issues we need to address in the current care system is to bring more funding into the care system, and the key point of the Green Paper is how can we bring more funding into the care system, but there are also issues around how the money that is currently in the system is used and whether that money is used in the best way. John, on my left-hand side, launched at the National Social Services Conference last week a publication called The Use of Resources in Adult Social Care. I would regard this as a seminal publication which is actually pointing out the differences in the way that the 152 local authorities invest their money. There are seven-fold differences in the way that some authorities invest in adult residential care, for instance, six-fold differences in the way that investments are made in services for people with learning disabilities. Our argument is that there is much more that can be done...
to use the resources which are in the current system more effectively and better, and the Green Paper is setting out an argument for how we should bring additional resource into the system to ensure that need can be met in the future: how we can meet need from changing demographics and the increasing number of older people, but how we can meet need from the changing nature of disability and the fact that some of us, while we are living longer, are not necessarily living healthier lives.

Q8 Chairman: Quite a lot of the time, when we talk about adult social care, we are talking about older people, but you make the point, rightly, that there are different issues that arise in respect of care and support for younger disabled adults and for people with long-term or degenerative conditions. What do you think we should be doing now? What is the difference in terms of providing care for these two quite clearly distinctive different groups?

Mr Behan: The Green Paper we see as being for all adults; that is, adults of working age (which is the phrase we have used) as well as adults who are beyond working age (older adults), and it is really important that we see the reform of the current system as being for all adults and not just for one particular group. As to some of the key differences, if you speak to people with learning disabilities or the many people with physical disabilities, their ambitions as working age adults will be the same as any working age adult. It will be to work and make a contribution economically as well as to make a social contribution through either family life or contributing to the community. Many older people will not have the same ambition to make an economic contribution, they will feel they have made that contribution, but they will want to continue to make a social contribution, a contribution to their communities, etcetera. What that means is we need to design a system where promoting independence for young working age adults will often be about how we incentivise people to go into employment, to maintain their employment, to live independent lives, in the same way that everybody else does. We have just taken on a National Co-director for Learning Disability, a young man called Scott Watkins, who is a man himself with a learning disability. He is employed by the department and works alongside our National Director for Learning Disabilities, and one of the things that Scott says that had a profound impact on me was, “Do you know, David, when I was at school nobody asked me what I wanted to do when I grew up.” There is a sense that that ambition for people with disabilities needs to be the same as the ambition for all of us who want to work and make a contribution. We think that is one of the differences. The other key difference that we expose in the Green Paper is that the asset base in this country is largely held by older people and not by younger, working age adults, particularly those younger working adults with disabilities. In the Green Paper we have tried to tease out a way of bringing funding into the system which is derived from where the asset base is held by older people. Our proposals in the Green Paper for the future of the care and support system is can we actually tap into that asset base through partnership based approaches, insurance based approaches. For many younger people with working age adults we do not feel that they will have the asset base in the same way, so what we have identified in the Green Paper is potentially different means to fund the services in the future for working age adults and older people based on that different asset base.

Q9 Chairman: One of the things that struck me (and we are going to move on and this question, I have no doubt, we will be asking further witnesses to this inquiry) is why there were changes in the system for people like this around further education. The type of young individuals you talk about now, when they get to the age of 26, are not paid for in the FE system any more. What did you think about that as an individual? That decision came along without much debate in Parliament, I think. What is your view about that?

Mr Behan: Of the things that we have done to support the policies that have happened this year, we have launched two important documents. One is called Valuing People Now, which is a strategy for people with learning disabilities, and a sister document to that is called Valuing Employment Now, and it picks up, Chairman, on exactly the point that you have raised, going back to Scott Watkins’ ambition to work, about how he feels that the system is not incentivised in a way to assist him into employment and then to support him into employment.

Q10 Chairman: Quite a number of these individuals actually were not likely to get into employment. Some of them actually thought they were going into employment when they were attending FE college, but that seems to have now stopped from the age of 26.

Mr Behan: If we look at the statistics for this, many people with learning disabilities in employment are below the levels of employment for people with disabilities generally and below the overall employment level. So through PSA16 we have been taking action to identify what is a critical path that many people with disabilities need to go into employment. There are some examples, both in America and in Scotland, of areas that have transformed completely the way that people can be supported into employment, including some profoundly disabled individuals who have been supported into employment. So we know of individuals, people with profound disabilities, who are being supported to carry out a job. In one case an individual has a paper round, but it is a job that he is encouraged to do and he is supported by two assistants to do that job, but the level of satisfaction and pride by achieving that job is there. I think what we are trying to do is define what employment opportunities can be developed and created and to look at how we can transfer current services into more modern innovative services based on that best practice, not just from America, but from Scotland, where there are certain areas that have transformed
Mr David Behan, Mr John Bolton, Ms Alexandra Norrish and Mr Jeff Jerome

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Mr Behan: Of course, there are routes that we can take based on that best practice. One of our jobs nationally is to demonstrate and disseminate that best practice to show others how this can be taken forward.

Q11 Stephen Hesford: Mr Behan (and, Ms Norrish, if you want to you can come in on this), social care is often seen as residual care as opposed to, say, the NHS, which is universal care. I think you have made that point already.

Mr Behan: Yes.

Q12 Stephen Hesford: Is that a fair distinction?

Mr Behan: Yes, I think 96% of us over the past 12 months will have consulted our GP, so it makes a point that healthcare is pretty much a universal service. I think 4% of us will use social care services this year in this country and about 40% of us will know somebody very directly who is also using social care services. In a sense, social care is very selective services targeted at those that are most in need, with primary healthcare in particular (acute healthcare probably slightly different) being a universal service which the majority of us will use. Where they overlap (going back to the Chairman’s earlier question), something like 68% of people who are in acute hospitals are people aged over 65. They are people who are elderly, who have healthcare needs as well as needs for on-going support to maintain their independence. So there is a point where healthcare and social care do come together and touch each other.

Q13 Stephen Hesford: If it is a fair distinction or description of where we are at this point, as the National Care Service has envisaged, will it change this distinction and, if it will, how will it?

Mr Behan: Certainly one of our visions that is described in the National Care Service is of a National Care Service working alongside the National Health Service and of the elements of the system that need to change. One of the drivers for those changes is closer collaboration between health and social care services at a local level, but, equally (I mentioned extra care, housing for older people), we actually need greater collaborative work in between housing and social care and, indeed, we need greater collaboration between the way that the benefit system operates and the way the social care system operates. So, at a population level, work that needs to be done to maintain people’s independence, to keep people healthy and well. In our Dementia Strategy one of our straplines is that the way to keeping people healthy of mind is to keep people healthy of heart. So all those issues around looking after our cardiovascular systems through exercise and diet are some of the things that we can do to ensure that we can keep healthy. Even in the early onset of dementia, there is a lot of evidence that activity and looking after people’s physical health can stop the progression of that particular disease, and it is at that point where we need to bring those wider local services such as leisure together with health services to ensure that we can continue to make some of the reforms that we so need to see in the social care services.

Q14 Stephen Hesford: So would you say that if the National Care Service came about, as envisaged in the Green Paper, someone in Durham would expect the same service as someone in Devon?

Mr Behan: Certainly one of the things that people have told us through the Engagement Strategy (and Alexandra and myself have done every one of these events), the message coming over from people who are using services loud and clear, is that people perceive the current service to be unfair, and the way they describe the unfairness in the current service is that you can live in Devon and in Durham and a person with the same needs could get two different offers and be invited to pay two different amounts of money for that offer, and when people come together and explain that, they perceive that to be unfair. So one of our ambitions in the National Care Service is of a service which is fairer, and that is why we talk about a national assessment system which is portable so that, if a person moves from Durham to Devon, or vice versa, they can take that assessment with them. We have also talked about national eligibility criteria so that people are clear about what they can expect from the system, where to go and how that service is to be accessed and how it will support them.

Q15 Stephen Hesford: Ms Norrish, has your boss got it right?

Ms Norrish: A very good question! I think one of the main points about the National Care Service is that we are, for the first time, moving towards the idea of a universal service for care and support which is based on rights and entitlements, and that very strongly came out of the discussions that we had with people during 2008. During the drafting of the Green Paper we went round the country and we talked to hundreds of people—members of the general public, people who use services, their carers, people who work in local authorities and health—and we tried to garner the key themes that came through, and the main point that came across from people who actually use services was that they were tired of a system which, in their view, treated them as charity cases, where they felt that they had to argue for the services that they needed in order to live their lives and which, as David was saying, they perceived as unfair because people in different parts of the country were getting different services. They did not...
know that one of the main problems, particularly for working age adults, was that if they were living in one area, they have got a service in that area, and then, for example, if they had to move to go to university or to follow employment, that was often a problem. They had absolutely no idea before they moved whether the new local authority would provide them with any support at all. So when we started designing the concept of the National Care Service, the basis of it was that it would be based on an idea of rights and entitlements where people would know what they could expect from the state, where there would be clarity and transparency and, essentially, that there would be universal elements, so that, as David was saying, for example, wherever you have your assessment carried out in the country, you know that you have a right to receive services that meet your needs wherever you move to. It does not necessarily mean that you get exactly the same services wherever you are, because if you are living in rural Devon you may actually need different services to those that you would need if you were living in the city of Durham, but what it does mean is that you will then have a right to have your needs met and be sure that you do have that flexibility. You have the ability to move around the country for employment, or for whatever reason, in the way that most of us would take for granted.

**Q16 Stephen Hesford:** Thank you. The 2007 Comprehensive Spending Review said that reform of social care funding should be consistent with the principles of progressive universalism. Do you recognise the concept of progressive universalism? 

**Mr Behan:** I think we do. It is not a phrase we use, because it is a phrase where normally people glaze over when it is used, but the concept as laid out is that those most in need receive that help and that help is targeted on those most in need. So it is progressive, it is about identifying those most in need, but it sits, as Alexandra has just explained, within a universal offer where people are clear about their entitlements. One of the things that people have told us consistently is that they are not clear about what the offer is or where to go get that offer. That was what was behind that statistic that 48% of people, just before we launched the Green Paper, felt that if they needed care in their later years it would be free at the point of need. It has never been free since 1948 in that sense; there has always been a means-tested system. So I think it typifies that the figure is not important, but a significant number of people do not have an accurate understanding of how the system works, so people do not make provision for it, they do not plan for it, so when they need to use the system it comes at them as a catastrophic event—it is something that they had not planned for—and they experience great distress in accessing the system at that time of need. So universalism for us, an offer around information and advice, around prevention, seems to be an absolutely essential plank of the reform of the system, as does personalisation, because what is important between Devon and Durham is that people are clear what their entitlement is, but it does not mean that everybody will get exactly the same thing. A young person with cerebral palsy in Devon and a person in Durham with, say, motor neurone disease might have a need for care and support but might choose to actually receive that support in very different ways. So personalisation is an essential plank of the Reform Strategy that we are taking forward.

**Ms Norrish:** I think it is helpful to distinguish between the elements of the National Care Service which are simply universal and those which are progressively universal. Progressive universalism, if it is a phrase that we are going to use, is attached to the funding aspect; whereas the other areas of the National Care Service are the universal offer and they are based on the entitlements. I think it is a mistake to think of the National Care Service purely as a funding mechanism. This is not just bringing the funding more into the status quo, we are actually trying to build a much better, much more robust system, and so when we were looking at the different areas within it, we identified six areas, five of which are the universal components—that is prevention, as David was saying, joined-up working and access to services, personalisation (I am mentally going round the hexagon), information and advice, and one other.

**Mr Behan:** Fair funding.

**Ms Norrish:** No, fair funding is the progressively universal. Do you have the hexagon? I have seen this so many times that it starts to blur. Yes, national assessment being the last of those components.

**Q17 Stephen Hesford:** So are we to bin progressive universalism, or is it the same as the National Care Service? 

**Mr Behan:** No, we are not to bin it, because in a sense it is a phrase which has been used. We have experience, though, of going out and talking at both the engagement events, where we saw thousands of people, people that work in the service and people who are using services, and we have just completed 36 events around the country speaking to people using the services. We calculate we have spoken to thousands of people again. Progressive universalism is not a phrase that ordinary people use when talking about accessing healthcare services. What is important is that we can have this conversation with ordinary people who are using services and who will potentially use services, in a language that they understand, and maybe for politicians, policy people, academics, it is a phrase that will have some resonance, but for ordinary people, we need to find different language.

**Q18 Dr Naysmith:** It is really a philosophical point, but this talk about progressive universalism and what you were saying earlier, Mr Behan, about perceptions of unfairness and so on, we are moving towards a universal service and it is the same everywhere. There used to be, in this country, and there is still in some parts of it and some parts of the world as well, the ability for local populations to raise a rate or a council tax and spend it on providing something for their residents that is not available
elsewhere. Is this now dead? Has local government the ability to assess what services the local locality needs and wants and to provide them?

**Mr Behan:** Currently (and John will provide the detail on this), as I said in answer to the Chairman’s question about the difference between health and social care, the funding for social care is largely made up of grants from government, what is raised locally through the community charge and through the charging regimes and grants from the Department of Health. At the minute the evidence is that local authorities have continued to raise money at a local level and made a local decision, in some cases, to invest in social care, and they have been largely local decisions. In the Green Paper, in the section on funding, we have raised the question of whether that system should continue or not or whether there should be other ways to do this. So we have couched this—

**Q19 Dr Naysmith:** You are waiting to hear what people think of that idea?

**Mr Behan:** Yes. The consultation closes on 13 November and at the minute largely links to the point about how people experience differences from one part of the country to the other. On the service delivery end of this, people experience it as being unfair. We have to say, at this particular point in the consultation, the issue about whether there should be a move towards national funding or whether there should continue to be a mixture of national and local funding generates a lot of heat.

**Q20 Mr Scott:** To be balanced, I am going to start with Alexandra, if I may. Is not the idea of a part universal (although I hate the terminology) and part targeted system just a fudge that risks giving the worst of both worlds and disappointing everyone? It promises a coverage that is universal, but most people will still have to pay substantial sums, and it promises to target resources on the poorest, but, of course, vast amounts of money will be spent on those better off.

**Ms Norrish:** Again, I think this goes back to the question of what is the universal element and what is the potentially means-tested element. In the care services we have got that are mapped out we have got the five areas which everyone would be able to get, and those are largely focused on services which help to keep people well for longer. For example, the offer around prevention is aiming at keeping people’s levels of need lower so that they do not get to the point where they need very expensive services. Then, on the fair funding component of the system, and fair funding was the wording that we found to replace progressive universalism—

**Q21 Mr Scott:** Thank God for that!

**Ms Norrish:** People generally understood it better, we found—we have got three different funding options laid out in the Green Paper, and we have been consulting on those and, as David was saying, the consultation is still running, but each of those, if you like, consists of a difference balance of support from the state and the individual. So you have got the partnership option where everyone who meets the needs criteria would get part of their care paid for by the state, so a quarter or a third for example, people who are on lower incomes would get more support and people on the lowest incomes get 100% of their care for free. What that means is that the majority of people of working age who have care needs will be getting their care for free; whereas a large number of older people would actually be making a contribution to the cost of their care. So that is the first option. Then there is insurance, which is based on the partnership model. So everyone, again, is getting that basic minimum of support from the state, but, then, people who are at risk of having high care cost can, if they choose to, take out insurance, either privately or through the state, which will cover the costs. Then the final option is what we have called the comprehensive system, and this is closer to an NHS model in that everyone in the country gets care free at the point of need but people of working age get that free care funded through contributions from general taxation, whereas there would be a separate funding system for people who are over 65. This goes back to the point that David was making earlier about the fact that, actually, a huge proportion of the asset base of this country is based in that age group. So when we were looking at how you would draw together the funding for the system, we identified a system which actually funds people who are over 65 separately through contributions that that generation have put in. So, if you like, all of those have got different levels of universalism.

**Q22 Mr Scott:** That would be means-tested for over 65.

**Ms Norrish:** The comprehensive system? You could run it in different ways. You could either have a flat rate contribution, so there would be an element of means-testing so that everyone who could afford to would pay a flat rate contribution into the system, or you could have it as a fully means-tested contribution so that people pay what they can afford to, potentially, up to a cap. Again, we have talked about this in a lot of detail at the events we have had around the country, and you find there are strong arguments on both sides and not necessarily the divisions that you might expect around people’s preference for either a flat rate or a means-tested contribution.

**Mr Behan:** Just to add to that, one of the key issues under the models we have developed in the Green Paper is you can, effectively, cap liability; whereas under the current system, with 20% of people paying costs into the system, they are paying over £50,000 a year into that system. So what we have tried to do is strike a balance between the premium that people pay where they will get services in return for that premium which allows people to cap the costs and the liability that they have got in relation to the system, so there is an important trade-off taking place here, but each element of the models we have developed has, in some part, a universal offer, which is about the state helping people to maintain their independence.
Q23 Dr Stoate: I would like to move on to Mr Bolton and talk about money. We have heard this morning. I think the figure is, that around £16 billion is spent currently on social care. Is that about the right figure?

Mr Bolton: That is the amount of money that is spent by local authorities on adult social care. Of course, if you talk about the total spend on social care, you would have to add on that which private funders would also be paying for their own care.

Q24 Dr Stoate: Do you know what size that is?

Mr Bolton: We do know the size of that. We know it is about 20% of the domiciliary care market, which would equate to just over £400 million, and we know it is about 30% of the residential care market, which would equate to just over a billion pounds.

Q25 Dr Stoate: Let us say we are talking about, roughly, 16, 17, 18 billion in total. Can you give us a break-down of where that money is coming from?

Mr Bolton: Where is it coming from? We do not know that. We do not know the detail of that because of the reasons that were identified earlier: because the Treasury makes a settlement to local government and then local government makes a decision as to what proportion of its money it is going to allocate to adult social care.

Q26 Dr Stoate: They do not give you any figures as to what percentage of money spent by local authorities comes from central government and what comes from their own resources. You do not have any idea.

Mr Bolton: No, we have no direct idea on that.

Q27 Dr Stoate: That is interesting. That leads to a wide variation, then, does it not?

Mr Bolton: Yes.

Q28 Dr Stoate: That clearly is going to impact on services.

Mr Bolton: Yes.

Q29 Dr Stoate: That is, obviously, one of the things we need to look at. Do we know where the money goes? If you do not know where it is coming from, can you prioritise where it is going?

Mr Bolton: Yes. The way we collect data is that local authorities produce for us an annual return on where they have spent their money. We have that information on where their money is spent, and so we know, for example, just under 60% of the money is spent on older people, about 23% is spent on adults with learning disabilities, and that is particularly interesting because that is massively increasing year on year, that is the big area of growth of spend, whereas the older people spend is flat, if not slightly falling, in recent years. We know that about 10% of the money goes on younger adults with disabilities and 7% to 8% on younger adults with mental health problems, and we know what proportions of that come from residential care, or domiciliary care, meals on wheel, etcetera.

Q30 Dr Stoate: We have no idea where the money is coming from. We have a better idea of where the money is going. Do we have any idea at all about what we are getting in terms of outcomes? Is anyone measuring what value of money and what outcomes we are getting for this cash?

Mr Bolton: There is a measure, in terms of a productivity measure, which looks at the numbers of people in the system being helped and the money that is available to them.

Q31 Dr Stoate: That is process, not outcome. We know how many people are being helped but no idea what the outcomes are?

Mr Bolton: Not beyond the cost of a particular package.

Q32 Dr Stoate: Does it not worry you that we are spending very significant amounts of public money, we are not sure where it is coming from, we are not totally sure where it is going and we certainly have no idea what it is being used for in terms of outcome?

Mr Bolton: Not as a pure science, as an outcome. That is very hard to measure, of course.

Q33 Dr Stoate: It might be hard to measure, but, as we are talking about some fairly big numbers and some fairly important issues in terms of social care, it is fairly important to know if the money is actually going to something worthwhile or whether, in fact, it is being spent on things that are not worthwhile, and we do not really know, do we?

Mr Bolton: The only way we know that is the way in which the system is regulated through probably the Commission for Social Care Inspection and the Care Quality Commission that will at least give us measures on whether they think outcomes are being successfully delivered by councils, but they are broad judgments, they are not detailed judgments, and they are not linked to the use of the money.

Q34 Dr Stoate: Let us move to a slightly different tack. Much local authority money is spent on people with the highest level of need—that is what we are being told—and many local authorities do not meet the lower levels of need at all, only the higher levels of need. Do we have any idea of the levels of unmet need?

Mr Bolton: No.

Q35 Dr Stoate: None at all?

Mr Bolton: No.

Q36 Dr Stoate: So we have no idea what is out there.

Mr Bolton: No-one collects that data.

Mr Behan: Can I add two things, if I may? The Office for National Statistics have done, over a number of years, work on productivity. Interestingly, in terms of your challenge about outcomes, productivity is normally measured by dividing inputs and outputs.

Q37 Dr Stoate: That is activity, that is not outcome. Mr Behan: No. I will come to the outcomes point. Your challenge is a good one, and we have been working on redesigning the performance framework
which is used by local authorities for social care so it is much more outcome focused, so that we can move to a more outcome focused approach. As John said, it is difficult to measure outcomes for individuals. We recently published, last year, a report on the evaluation of individual budget pilots where part of the research methodology was to explore exactly what your challenges are, which is outcomes for people, and the results of that evaluation demonstrated that, compared to a randomised control group where people were using individual budgets, particularly people with mental health problems, people with learning disabilities and younger people with physical disabilities, their outcomes, expressed as satisfaction in the quality of their opportunities, was up and greatly in excess of the outcomes for people using more traditional forms of service. Some of the evidence on which we are basing the agenda for personalisation and the use of personal budgets is on the back of outcome studies of our work; so this is an area where we are increasingly undertaking outcome-based work. At the present time we do not have a sufficient range of outcome information that we would need to drive this system forward, but it is something we are addressing.

**Q38 Dr Stoate:** We will come back to Mr Bolton. I would like to look at the future. Do we have any projections of demand, for example, between the years 2026 up to 2041? Have we got any forward figures?

**Mr Bolton:** This is Alexandra’s area. This is exactly what the Green Paper has been looking at.

**Ms Norrish:** Yes. The modelling that is being done by the London School of Economics is looking in the most detail at the first 12 years of the new system, which is 2014 through 2026, so that is the time for which we have the most detailed modelling. I believe I am right in saying that the LSE model does go, in terms of its demographic projections, all the way up to 2041 and that we have done those extrapolations forward. The problem, of course, is that the further you go into the future, the more and more unreliable it becomes, partly because all we can do, in a sense, is extrapolate forward from the status quo and the number of variables—for example, if a cure for dementia were to emerge, that could completely throw your projections—and so we have mainly concentrated on the period of time which we feel is more robust and more reliable.

**Q39 Dr Stoate:** That is fair enough, and I accept your answer on that, but are future proposed funding models robust enough to take account of these variations so that we can make some sensible projections? If we are asking people now, for example, to put money into a pot to pay for their future care needs, and that is one of the proposals we are looking at, we must have some vague projection as to whether that is going to be enough, too much or woefully inadequate.

**Ms Norrish:** Absolutely. That is the essence of the modelling that we are doing on the Green Paper.

**Q40 Dr Stoate:** How robust is it? Is it good enough?

**Ms Norrish:** We think it is a very robust model. It has now, I think, been developed by the LSE for three years. We have put in a whole range of different assumptions. We have sensitivity tested it. Obviously, we cannot control for what we do not know, but I think the question you are asking, as I understand it, is: are our predictions about the amount of money that you would have to put into, for example, the comprehensive system robust? We are continuing to work on them, we are refining them all the time, and we are working very closely with other organisations like DWP, who have the model Pensim, which is the projection of costs of pensions. So we are looking at how we can ensure that the various sources of modelling that we have are ensuring that these numbers are as robust as we can possibly make them.

**Mr Behan:** There is no country in the world that has actually bottomed this. The author of one of these models, I think, is advising the committee, Chairman, so there is a sense whereby we are satisfied that this micro-simulation model is as good as anything there is. We looked at Germany, Japan, France, we looked at how they were doing their figures, and the reason we have formed the relationship with PSSRU. LSE is because we think it is a good model. Clearly, the Green Paper states this is a statement of direction, these are the principles that we are working on. Once the Government makes its decision and chooses which option to go for, what we will do is we will model that in detail and, clearly, we will crunch down some of the broad assumptions that are in there and work out alternative scenarios. Given where we are, where we have identified the challenges from demography and changing expectation, the model has allowed us to put forward the propositions on which the Green Paper is consulting, and once a decision is made about how we should move this forward, we will actually turn to this model again. This is a waking up in bed at three o’clock in the morning moment thinking: is this the best model? It is the best model that there is internationally and that is why we are running with it.

**Q41 Dr Stoate:** I do accept that. My final point is that, if we have no idea what the unmet need is at the moment, we have got a scant chance of finding out what it might be in 25 or 30 years’ time.

**Mr Behan:** One of my previous jobs was Chief Inspector at the Commission for Social Care Inspection. We did do special studies to try and quantify unmet need. The problem with it (which is why we do not have any absolute figures on it) is that there has been no research on unmet need which has been verified, no randomised controlled trials to take us forward in relation to that, and a key issue here is that demand for social care is elastic. The issue we are trying to sort out (which is why the model is so important), in just straight economic terms of basic principles of supply and demand, is just how elastic is that demand. The difficulty we have got in answering your question and why the model is helpful, is that it allows us to challenge some of those
assumption about the elasticity of demand. So if we reduce or increase charging, what would that do in terms of people coming into the system or people not coming into the system is a really fundamental question, it strikes us, and, of course, what assumptions you make in any model about those things could bring in, or exclude, a given number of people. So the difficulty we have got in modelling is not that we want to be elusive about answering your questions, I think the questions are absolutely correct, Chairman, but it is how do you measure the elasticity of demand where people will change their behaviour about whether they come in the system or not in the system? In the CSCI report we have made some quantifications about unmet demand by a point right at the beginning to the Chairman that if the formal system does not work adequately, what happens is that people either do not come into the system or their informal carers pick up the responsibility of caring. That is the difficulty.

**Dr Stoate:** Thank you very much for that. That is helpful.

**Q43 Chairman:** Again a question for John and Alexandra. The Prime Minister recently announced that we were going to have free personal care at home for those with greatest need. I wonder if you can tell me how will this be paid for, how many people will be eligible, how many of these will be people who would otherwise be self-funding and how exactly does this relate to the options in the Green Paper?

**Mr Bolton:** This is really a question for David, to be honest, but we can give you some indication. The money that has been made available for free personal care is a figure of £670 million, which is made up of £420 million contribution from the Department of Health and £250 million from Communities and Local Government which, they say, local authorities will find through efficiencies.

**Q44 Chairman:** So it is not new money.  
**Mr Bolton:** It is not new money to us to do that. We are now working on the details of what that money will bring us in terms of the opportunity for free personal care to people with the highest need; so we are looking at various modelling. We are looking at the current models of what information we have about local authorities, we have been particularly looking at those people in local authorities who have critical needs as identified under the Fair Access for Care, and we can make a reasonable projection on the amount of money that is being raised by local authorities under their current charging regimes for people who would become eligible for free care during that. We are then trying to look at the question which you ask, which is much more difficult to identify, which is the numbers of private funders who will have critical needs who could become eligible if this is what the scheme looks like. As identified earlier, we have identified this figure of £420 million that is being spent by private citizens at present on paying for their own domiciliary care, but there are two factors. We do not know what proportion of those would be in the category of critical and we do not know what the increase in demand might be when we made the offer. So, again, we are working on the similar models that the LSE have used for the Green Paper to try and project ahead.

**Q45 Chairman:** Were you expecting this announcement or were you surprised by it? I see you smiling, John. Were you expecting this announcement or were you surprised by it?

**Mr Behan:** We were expecting the announcement.  
**Chairman:** You were. Is there anything further to add? I think you have covered the areas about which we would like to know. Maybe we should move on. Sandra.
Q46 Sandra Gidley: You mentioned that you did not know quite how many people would fall into the critical band, but does not this policy create a couple of perverse incentives, the first being that there will be, or could be, councils who manipulate the criteria to try and escape having to fund this? What is going to stop that happening?

Mr Bolton: That will be mostly through the regulation, the performance regime, that would challenge councils who are seen to be putting perverse incentives into the system.

Q47 Sandra Gidley: How do you actually pick up on it in practice?

Mr Bolton: Looking at the data. If there was, for example, a significant increase or decrease in the numbers receiving care.

Q48 Sandra Gidley: You have just said you do not collect that information, in answer to an earlier question.

Mr Bolton: We know the types of care people have, so you could look at the trends. It is one of the things we have been looking at. Actually there already is significant variation in what councils offer people, which is part of the wider issue, so actually we are very keen that the regulators also pay attention to those issues in their current regulation and particularly in their future regulation.

Q49 Sandra Gidley: What is to stop councils shunting people into residential care, because that is going to be funded differently, and the council will not have to take quite such a hit?

Mr Bolton: Supply would be probably the biggest thing that would stop councils from doing it, because it will depend on supply being available.

Q50 Sandra Gidley: Let us assume there is some slack in the system, which there is in some areas of the country. What is to stop councils from doing that?

Mr Bolton: It will be through regulation. It has been government policy for twenty-something years now that local authorities should give prime consideration to how they can support people to retain independence, to live in their own homes, to live in their own communities. The performance framework is there to support and we hope in the future to drive that behaviour. So that is the way people get overall monitors, through the performance framework and through the regulator checking that government policy is being delivered to this end.

Q51 Sandra Gidley: Can I clarify who is going to check all this? In answer to an earlier question—I think I have to return to this point—you said, “We do not know how many people are assessed with each criteria with each local authority.” Now you are telling me you can look at the changes in data, the changes in trends and work out if there has been some manipulation of the system. I am sorry; your two answers are incompatible.

Mr Bolton: I do not think that is what I said to your earlier question. Some local authorities do know the data as to those people that they have assessed as to which category they fitted into: critical, substantial, moderate or low. Not every local authority keeps that data—we are aware of that. We do have data from some authorities just in that first area. In relation to the second bit, I think what I am suggesting is you could still see the overall trends of direction. For example, what I look at is where councils are spending their money.

Q52 Sandra Gidley: Not if you do not collect the data, though.

Mr Bolton: We collect the data on where they spend their money, and you can see the directions of where they are spending their money, whether their money is going more into supporting people to live at home in the community or whether their money is going more towards supporting more people in residential care. That would be the way you could actually map what you are asking for in terms of whether people have changed their behaviours as a result of the policy.

Q53 Sandra Gidley: But you are going to be picking this up some time after it has happened.

Mr Bolton: You certainly would.

Q54 Sandra Gidley: The other perverse incentive is that families might want to keep their elderly relatives out of residential care when, in fact, that might be the best option for them. What is to there to prevent that happening?

Mr Bolton: There is nothing particularly, except within the same patterns. It would be monitored through what the regulator identifies through their regular review meetings or through inspections.

Dr Taylor: These are also to John and Alexandra. I am very conscious of Mr Jerome sitting here. His turn is coming.

Chairman: You are on the next page, Mr Jerome. Keep the faith!

Q55 Dr Taylor: Can we go on to try and pick up some detail about the type of domiciliary support that people will be able to expect under the new system. Will it be just personal care—dressing, eating, toileting—or will it include support with other activities, like getting out and about and leisure activities, social activities? Could you fill us in with some detail?

Mr Bolton: I have to say, we are still working with ministers on this policy. In terms of what the finances look like, it does look like the most potential option is to focus on personal care.

Ms Norrish: That was the text that was actually in the Prime Minister’s announcement. He did actually announce free personal care.

Q56 Dr Taylor: But if people are getting money channelled to themselves, would they be able to choose to use it on other things?

Ms Norrish: I think the answer to that is that the details of exactly how this is going to be—
Q57 Dr Taylor: We do not yet know.
Mr Bolton: In the spirit of personalisation, the answer has to be, yes.

Q58 Dr Taylor: But we have no detail or confirmation of that yet.
Mr Bolton: We are still working on the detail of that.

Q59 Dr Taylor: When do you think we will get that?
Mr Bolton: I think I have indicated that the detail should be available within the next month.

Mr Behan: If I may, Chairman, the Prime Minister’s commitment was for free personal care. Personal care, as defined within social care, is assistance with washing, dressing, bathing, etcetera. It is not, and never had been, interpreted as being assistance with accessing leisure pursuits, etcetera. So the way that we are working is how can we develop the offer to people so that it can support people in their independence, can sit alongside, going back to one of the earlier questions about what we know is effective in the way that we can operate, about can we help people may have been in hospital, who are coming out of hospital, where the evidence is that if we re-able people (to use a phrase), then they can go on to live independent lives in the community. So we want the focus to be ensuring people can be maintained in the community. It goes back to Sandra Gidley’s questions about incentivising the system, and it is critical that this offer incentivises people to be maintained in the community. That is the Government’s policy and it is based on what people have told us they want to see from services, where people have said, “We want to be assisted to live at home.” So the design of the policy will be about how can we continue to assist people to remain independent and live in their own homes, but the Prime Minister’s statement was to offer personal care.

Q60 Dr Taylor: Going back to Alexandra, when you were talking about what was universal, you said there were five areas for everyone. One of those you mentioned was prevention, which is keeping people at home. Did you say the others? Did I miss the others?
Ms Norrish: I did say them.

Q61 Dr Taylor: Could you list them so I could write them down?
Ms Norrish: I could, yes. May I borrow the picture again so I do not miss one out? There is prevention.

Q62 Dr Taylor: It is that diagram?
Ms Norrish: It is this diagram, yes. It is the hexagon. It is prevention, assessment, joined-up service, information advice, personalisation and fair funding.

Q63 Dr Taylor: Would you agree with one of our advisers, who suggested a move from the focus on eligibility as a boundary for local authority responsibility? Do you think there is a move away from eligibility as being a boundary for what local authorities are responsible for?

Ms Norrish: I think that what we are moving away from is a service in which local authorities have no responsibility for some people in their area in practice. In theory and in the law, local authorities are required to provide an assessment to anyone who wants one, are expected to provide information and advice, but we know in practice that frequently that does not happen. We have spoken to many, many people who have said they have tried to approach their local authority for information or for help and in some cases they have had no response at all, in some cases they have been signposted on to Age Concern or one of the organisations in the voluntary sector. I think what a move to a universal system does is it breaks down that barrier; it moves away from a system which only some people, the poorest essentially, are sure that they are going to get any help from the state into a service where everyone in the country who has a care need is entitled to at least advice support from the state.

Q64 Dr Taylor: So elderly people who are financially reasonably well off but are utterly alone in the world could benefit from some help?
Ms Norrish: They would benefit from the support around information and advice, they would benefit from the reforms to assessment to make the process easier to manage, so, yes.

Q65 Sandra Gidley: I want to come back to this notion that everybody wants to stay at home and that is what people tell us. We hear this mantra constantly. We also hear about personalisation, people are supposed have free choice, but actually there was a paper produced—it is probably four or five years ago now—by the Social Care Institute for Excellence which surveyed people of the generation yet to access care and a proportion of them said, “Actually, no, I do not want to stay at home if I cannot have my normal life. I would quite like to go into a home.” Why are you disregarding that 20%, where is choice in all of this for the individual and are we convinced that staying at home is the best?
Ms Norrish: Generally, the evidence we have about people going into residential care is that for those people who enter it too early, it actually reduces their outcomes. In particular, it reduces mobility, it reduces people’s independence, it reduces their flexibility. Somebody who has been living at home and has been having to think about going to the shops or organising their life to some degree is suddenly put into a much more potentially passive situation. The evidence that we have got is not particularly strong around this, but the evidence that we have got suggests that actually people tend to go downhill more quickly if they are put into residential care. There does come a point at which actually someone is so physically disabled or in such a high level of need that residential care is the best way of providing the care that they need. I think the other point that you are making is one about isolation and is about residential care being a better solution than someone just being stuck in their sitting room not being able to get out and see people from day to day, and I think you are absolutely right, but I do not
think it is a binary answer. I do not think it is either people living at home or people being in a residential care home. There are other ways you can help someone to be supported in the community actually to get that sense of emotional support back without having to put them into a residential care home when actually the fundamental problem is not that they need 24-hour support but it is just than they are lonely.

Q66 Dr Stoate: I would like to press on a bit more with my funding questions. Alexandra, the Green Paper does not tell us how much the various funding options would raise. Are you in a position to tell us what those figures might be?  
Ms Norrish: The costings of this are all in the impact assessment. There is a table in the impact assessment which lays out the cost of care to both the state and to individuals. So, yes, the costings are all in there.

Q67 Dr Stoate: That is the cost of care. Do we know how much money is going to be raised by the various funding options?  
Ms Norrish: Essentially what this captures is how much the state puts in and how much individuals would have to put in to meet the cost. The level that the state puts in, of course, is subject to decisions made in future spending rounds—so that is why, in a sense, we cannot absolutely say this is how much money will come from the state, this is how much will come from the individual—but, if you like, this is the overall total and this is how at the moment we have got it split.

Q68 Dr Stoate: Have you done any work on what might be an acceptable level of tax burden and proportion of GDP that might be spent on this?  
Ms Norrish: We have got a number of different scenarios in the modelling. As we go forward, if we were to keep the proportion of funding that comes from the state and the proportion of funding that comes from the individual stable at the level that it is at the moment, funding from the state needs to increase by 3.2% per year, and that figure is in the impact assessment, but, clearly, that is just, if you like, a mapping of one potential way of measuring the proportions.

Q69 Dr Stoate: The Green Paper does not set out in much detail what implications this might have for people of working age. Do we have any figures or any idea about that?  
Ms Norrish: When we were looking at care for people of working age, we found that the vast majority—I cannot remember the exact figure but I am sure it is upwards of 90%—are actually getting their care paid for by the state already, they are not making any contribution towards the cost of their care. So what we have done is just extrapolate forward, essentially, that people continue to get their care paid for by the state, and that is paid for out of general taxation, as it is at the moment.

Q70 Dr Naysmith: Ms Norrish, the Government has ruled out transferring the budget for Disability Living Allowance into the social care funding system. They are going to do it with Attendance Allowance. Many people fear that they will lose this vital means of paying for extra (i.e. non-care) costs and get nothing in return, possibly ending up as net losers. Is there any calculation available as to the likely winners and losers, what protection can be offered and what arrangements are envisaged for this possibility?  
Ms Norrish: What we said on disability benefits in the Green Paper was we are looking only at benefits for people who are over retirement age. So we are not looking at Disability Living Allowance for people under 65. You are right on that. What we did when we started to model this was we looked at the various sources of funding that are available to people during their retirement years, and we looked to see whether any of them overlapped or were inconsistent with each other and we found that the two which overlapped most closely were social care funding and Attendance Allowance which were often aiming to achieve very similar outcomes but some people are getting both and some people are getting neither and are falling between the cracks. One of the proposals in the Green Paper is that you would take the two funding pots and you would combine them into one so there would be one assessment process rather than the two different assessment processes you have at the moment. On one hand that makes it a simpler system to administer. The consequence of it is for the first time you apply a means test to Attendance Allowance. The reason we did that was when we did a lot of work with DWP during the drafting of the Green Paper we looked at the data they had on Attendance Allowance and we found that while the vast majority of people who get AA need it, they are on low incomes and they have high levels of need and it is a really important part of their support and without it they could not function, there is a significant minority of people who are on much, much higher incomes who do not actually need the support that AA gives them. During the course of the consultation we talked to people around the country about this and I have had people coming up to me telling me stories about people they know who get their AA and put it in the bank and are keeping it “to pass on to their grandchildren”. There was one person I heard about who every year goes on a four-week Saga cruise and uses her AA to extend it to a six-week cruise. This is where we have to take a view on whether the best use is being made of public funding. The judgment that we took around that was that you could transfer that funding from the people who are on higher levels of incomes to people who are on lower incomes and who potentially have higher levels of need and so that is the proposal in the Green Paper. However, we do know that AA is a very popular benefit because it is flexible and it is transparent. It is flexible so you can spend it on whatever you want, you do not have to spend it on your care and you can get it in cash if you want to. It is transparent in that you know exactly how much
funding you are going to get. What we are looking at is how you bring the advantages of that into the new system. In terms of flexibility what we have said is that we are not just talking about putting this money in the existing social care system. In the National Care Service the Green Paper says everyone who wants a personal budget will be able to get a personal budget and a personal budget can be taken in part or in whole in cash, so people would be able to use that funding flexibly. The idea of a personal budget is that you can use it to decide your own priorities, so if what matters to you is spending your money on transport or whatever else it may be then you have got that flexibility as with AA.

Q71 Dr Naysmith: That is all very helpful. The point of the question is will there be some losers in this system, people who currently may get money for this flexibility, this personalisation? Who will lose out?

Ms Norrish: There will not be any losers amongst people who are currently receiving AA. One of the things that the Green Paper says is that everyone who is currently receiving AA would receive an equivalent level of support through the new system so nobody is going to lose out who is currently getting their benefits. In the future of course if you reprioritise then, yes, some people would be nominal losers.

Q72 Dr Naysmith: Some people have suggested that it is age discrimination to treat Attendance Allowance differently from Disability Living Allowance. Is there any validity in that accusation?

Ms Norrish: Age discrimination applies if you do not have a basis, a reason why you are treating people of different ages differently. The reason that we are looking at people receiving these two different benefits differently is people who are receiving DLA under 65 are almost exclusively on very low incomes. People who get DLA frequently will be unable to work and will not have had the opportunity to build up assets and will not have those savings and so they are in a very different financial position from people who are over 65 who potentially have worked all of their lives, who have savings, who have assets and in the last couple of years of their life develop a care need and so claim AA, so that is the basis.

Q73 Dr Naysmith: You think legally there is no strength to that argument?

Ms Norrish: We have talked to lawyers about this and they have advised us it would be alright.

Q74 Dr Naysmith: You were talking about consultations that have taken place but there seems to be quite widespread public ignorance about what social care is, how it is currently organised and funded and the options for the future. How can you overcome this ignorance? Lots of pressure groups have been speaking to MPs and so on but outside there seems to be a lot of lack of understanding about what is going on and what is being proposed.

Ms Norrish: I think social care is a system where there is much less public knowledge than there is for example of the NHS. It is not a recognisable brand and it is something, as David was saying, that comparatively few people at any one time are using although the vast majority of us will need it or have contact with someone who does at some point during our lives. In terms of how you build on that, how you increase the public awareness, we have been running what we call the Big Care Debate since the Green Paper.

Q75 Dr Naysmith: I was going to ask you about that. Not much seems to be happening with the Big Care Debate.

Ms Norrish: The Big Care Debate was launched on 13 July. Since then we have had upwards of 15,000 responses. We have run 36 events going round each of the regions. We have had 43 public roadshows and those have each been designed to be in city centres where there is a majority of people going past. We have had a so-called footfall of more than two million people so that is two million people who could have walked past and seen the material. We have had 78,000 hits on our website. We have had a whole range of media coverage. You may have seen the work that we did with the Guardian. We did a whole supplement on the National Care Service. We have done work with the media in all of the regions where we have had the events. We have had local radio, we have had local television there, we have had local journalists.

Q76 Dr Naysmith: Do you think you have done enough or are you doing enough? Have you a big enough budget for this?

Ms Norrish: You can always do more and all of my comms team advise me that when you are running something of this size and this scale it does not happen overnight. It is not going to happen overnight. It is something that we need to sustain and so that is very much what we are doing. I think we have got off to a really flying start.

Dr Naysmith: Thank you.

Q77 Dr Taylor: I hate to say it but I must walk around with my eyes closed and be completely deaf!

I had not looked at the Green Paper until we were about to start this inquiry and I had no idea that the consultation finished on 13 November. That is maybe a huge criticism of me but I really had not learned anything about it at all. What I really want to know is can you give us any idea of what is coming out of this, particularly on consultation question number three which is the funding options? Is there a consensus coming towards answering that?

Ms Norrish: We have not finished the consultation obviously.

Q78 Dr Taylor: No, I realise that but we are trying to get a feeling.

Ms Norrish: And I do not want to pre-empt anything that could come out of that. We have heard widely differing views argued with passion on both sides throughout the consultation, so I really do not want to pre-empt anything that comes out at this stage.
Q79 Dr Taylor: What is your plan—to publish all the responses or summarise them with those in favour of each of the three options?

Ms Norrish: What we have done is we have asked Ipsos MORI to work with the Central Office of Information who are running a lot of events for us and, as we did with the Green Paper, to produce an independent report. We have asked MORI to go through every single one of the responses that we have received and count them so that we have got both the qualitative and quantitative analysis of where people are coming from because we have got a lot of different strands of public response coming into this. At one extreme we have postcards which literally have a tick-box saying which funding option do you think we should have. At the other end of the extreme we have the contributions that will be coming in from our stakeholders of which many will be tens of pages long. We have the detailed comments we have had from our website and the various streams that are coming in from the write-ups of engagement events. All of those will be pulled together and analysed. What Ipsos MORI will then do is the report that they publish will have a section on each of the different strands and will pull together the results. We will not be publishing in full every single one of the responses we have had because, as I say, there have been 15,000 of them so far. I defy anyone to find that a riveting bedside read.

Q80 Dr Taylor: When do we expect Ipsos MORI to give us this sort of report or to give you the report?

Ms Norrish: We need obviously to give them the time to do the analysis. We do not have a publication date set yet but I imagine it will be in the New Year.

Q81 Dr Taylor: You have mentioned the theoretical footfall at the roadshows. At your 36 events what sorts of numbers of people did you actually get coming to those?

Ms Norrish: We have had anything between 80 and 100 at the majority of them. We deliberately set them so we had a Thursday afternoon, a Thursday evening, a Friday and a Saturday morning event in each region so that we could reach as wide a range of different people as possible, so, in particular, carers and working people who could not make normal working hours events were able to come to the Thursday nights and Saturday mornings. Thursday nights were often smaller but often very, very good discussions whereas the other events tended to be larger.

Q82 Dr Taylor: I am still completely puzzled why I have missed out on these entirely. So out of these 36 how many would have been in the West Midlands?

Ms Norrish: Four.

Dr Taylor: I still feel terribly guilty about this. I would love to know if other people have attended these or knew of them.

Sandra Gidley: No.

Q83 Dr Taylor: Everybody is shaking their heads so we who should be aware of these sorts of things were not.

Mr Behan: My understanding is that all MPs were written to. I will check that immediately I go back to the office. If Richard is worried he has missed out we can advertise the events on 3 and 4 November in Brighton and London respectively and if MPs feel they have missed out they have the opportunity to come and attend one of our final events. What you will see, just to expand the answer to Richard, is that a lot of the events are interactive, they are discursive and we ask people for instance to give their comments freely using different media. We then ask people whether they work in social care or they are a carer or they are a person who uses services to identify that by virtue of a coloured spot, and Ipsos MORI will then try and segment the views we are getting based on whether people are using services, caring or working in those services and so the richness of the data. That is why it will take them some time because it will not just be a quantitative assessment “we had this many in”, but there is some attempt to get into the richness of the information.

Dr Taylor: I would love to know if I did receive something.

Chairman: Can I just say, Richard, I knew about the further consultation and the other Rotherham MPs and I have sat down with the Rotherham Pensioners Action Group and discussed it in detail and they submitted in and they sent it to me as well.

Q84 Dr Naysmith: Have you had one in Bristol?

Mr Behan: Yes we have.

Q85 Dr Naysmith: Have you had one in the South West?

Mr Behan: We have had four in the South West. There have been four in every region.

Q86 Sandra Gidley: Some of the regions are very big though but I think we need to move on. Alexandra Norrish, can you briefly explain to us the choice that Norrish, can you briefly explain to us the choice that the Green Paper poses between a fully national model and a part local/part national model?

Ms Norrish: When we designed the funding options around the Green Paper and when we were having the discussions with people last year, one of the big issues that people told us about was the postcode lottery that meant that people in different areas received different levels of funding, and so the Green Paper contains two options around ways in which you could design the funding system to move towards the National Care Service and really the question is how national is the National Care Service? The fully national option involves central government setting the level of funding that people with a particular level of need and who need a particular outcome would receive. It is closer to the Attendance Allowance model in that it would be something like a national tariff whereby that individual would know that they were going to receive £200, or whatever it might be, and then if they move to a different part of the country they would continue to receive that same amount of money. This ties into the portability proposals in the Green Paper so essentially your care is standardised wherever you are. You could flex that. There would
be a formula that would mean if you were in a more expensive area you would get slightly more, etcetera. That is the fully national option and the implication of it is that it would have an impact on council tax. If you are essentially telling local authorities how much they have to spend on each individual in their area then it is no longer fair to expect them to be contributing to that cost through raising their own council tax, so you would have to reduce the level of council tax and raise more funding at national level. The part national/part local system is closer to what we have in the current system and it retains more local flexibility and retains the ability of local areas to raise council tax towards their own priorities if they choose to. So what would happen would be that the individual would still have their assessment which would be carried out in the same way wherever they were in the country. They would know they had a right to have their needs met but then the local authority would be responsible for identifying exactly how much money that particular individual was going to get in that local area in order to meet their needs. The advantage of that is that it gives you the local flexibility. We have had some people, particularly people working in local authorities, telling us that in their areas the costs of care vary literally street-by-street or village-by-village and so the part local/part national option enables the system to be more responsive to that whereas the disadvantage of it of course is that it retains the fact that people would be getting different levels of funding depending on where they lived which they may still perceive as a postcode lottery.

Mr Jerome: It is the latter. My role is one created on the back of the Putting People First concordat which hopefully the Committee knows about in terms of the agreement between central and local government and other key partners to actually try and move forward on a “partnership co-production”, is the term but I am trying not to use that one because it is not a very user-friendly term, in the spirit of working across the partnership to move the Putting People First agenda forward. The thinking was that if we can create a role that works particularly from a sector-led basis (a sector being local government in this particular case) but accountable, if you like, to a partnership between local and central government that the sector will be able to encourage itself on the delivery side to move forward. I am predominantly working on the local government side to a partnership of the Local Government Association and the Association of Directors of Social Services and to the Department of Health but I am not accountable to the Department of Health; I am accountable to a consortium of those three organisations and I link to the Putting People First programme board which is chaired by John Bolton.

Q89 Stephen Hesford: So are you ultimately accountable then to the Secretary of State for DCLG? Is that how it might work?

Mr Jerome: No, I am not accountable to any Secretary of State. I am accountable to the organisations that could be accountable to two Secretaries of State in fact.

Q90 Stephen Hesford: Targets have been set in this area. What powers are there to oblige local authorities, as commissioners and providers, to meet them?

Mr Jerome: If you are talking about the targets being the ones that we have set out particularly in the Milestones document that we recently sent to local authorities, what we are trying to do is to say there is a concordat, we support this direction of travel absolutely and totally on the local government and Association of Directors side, and we think it will now be helpful in terms of creating some pace in terms of progress to set out some markers that we think local authorities need to work alongside.

Q91 Stephen Hesford: But in simple terms what are those milestones and targets?

Mr Jerome: They are milestones as opposed to targets. It is the definition of a target. They are not part of the performance regulatory regime, if that is what you mean, but we are expecting that people will try and meet those.

Q92 Stephen Hesford: What are they?

Mr Jerome: There are five areas basically. There is one around engagement and partnership. It is partly a leadership approach, how well are councils and their partners, particularly users and carers, engaged in creating this programme to make clear what the programme is, to be involved in decisions about the programme, etcetera. We have got another on investments in prevention and intervention services...
so that there is some evidence around the way in which local authorities are investing in preventative services and targeted intervention. We have another that is relating to the operating model, if you like, the system that creates personal budgets for people. I usually explain that as everybody getting the public sector offer, public sector money, knows the pound sign associated with that. That is the personal budget. We have put down a marker on that one particularly that we want local authorities to hit 30% of those people who receive council services having a personal budget or a pound sign by 2011. The other one is around information and advice, and you have heard a bit about that already, so that there are clear programmes and clarity about access to information and advice and actual evidence that there is good access to information and advice by March 2011. Then finally there is one about commissioning, particularly with the NHS and other partners, around the sorts of areas including the efficiencies that arise from that over the next 18 months of the programme.

Q93 Stephen Hesford: And consumer resistance to any of your milestones; which is presenting a problem, if any?
Mr Jerome: I do not think there is any resistance. There is clearly concern in some quarters about certain aspects of that. I think the two I would probably pick out are some people would probably be concerned about their ability to meet personal budgets targets by 2011 and the other area is probably in relation to the NHS, how easy it will be to get the NHS to work alongside local government in that timescale and getting that matched together. Those are the things that come back to me most from local authorities.

Q94 Stephen Hesford: Finally, are you familiar with the Adult Social Care Reform Grant?
Mr Jerome: Yes.

Q95 Stephen Hesford: Is that a factor? Is that helping?
Mr Jerome: Is that helping? Yes. That has gone to local authorities and to regions and there are regional programmes both through the Regional Efficiency Partnerships but particularly in this case through the Joint Improvement Partnerships that are chaired generally by directors of adult social services. They have all got programmes in relation to Putting People First and there is also money in local authorities. What we know from our survey last year is that local authorities are using that productively both internally and externally with providers to move this programme forward.

Q96 Chairman: Could you just confirm, is the Secretary of State ultimately responsible for what the Government call the Social Care Transformation?
Mr Jerome: Well, it is a policy objective.
Mr Behan: I am not sure whether you want me to come in, Chairman.

Q97 Chairman: I was asking Jeffrey. I just wanted a yes or a no to that question.
Mr Jerome: Yes it is and David can give the answer.

Q98 Dr Taylor: Can I go back to some of the definitions of terms used by the Government some of which we have used and heard about already. What do you understand by “personalisation”? Mr Jerome: You have heard it already but effectively it is setting out care and support services around individual needs rather than always doing it on a collective basis. That is probably the simplest way to put it.

Q99 Dr Taylor: “Self-directed support”? Mr Jerome: Similarly it is a concept where ideally individual users or their carers will be in charge of the arrangements that are put around people, bearing in mind not everybody has full capacity so there are things that you may need to put in place to assist that.

Q100 Dr Taylor: Those are fairly easy to grasp. I think “Individual budgets” and “personal budgets”? We have been given a diagram from the Department of Health and it describes individual budgets as “a clear up-front allocation of money that can combine several funding sources that you can use to design and purchase support from the public, private or voluntary sector” and the personal budget “like individual but solely made up of social care funding”. It appears that the Department of Health is moving away from individual to personal. Is that right and why are they doing that?
Mr Jerome: We put something out last week to help councils and others clarify that. The main issue is individual budgets was a pilot looking at a number of public sector funding streams. In fact, that has now been picked up by something from the Office for Disability Issues through the Right to Control Trailblazers which Members here might know about which is going forward into legislation. There will be some further piloting of public sector funding streams under something called “right to control”. Individual budgets was just something that happened in councils some 18 months ago which were looking at that. We are trying to make it clear to people that that is something that has gone and moved into right to control, but the term we are trying to get everybody to use is “personal budgets” which is at the moment about the social care money only and of course links to the term “personal health budgets” and makes it easier for people to understand in terms of what is going to happen on the health side.

Q101 Dr Taylor: Did the pilots not work then?
Mr Jerome: It might be best if you ask colleagues in DH about that because that was a Department of Health set of pilots.
Mr Behan: Can I help, Chairman. I think one of the issues about the session is that Jeff is being asked questions which are really about the accountability of DH officials and I would regard myself as being the senior official responsible for this. In straight
answer to Dr Taylor’s question, the individual budgets that were piloted, which in effect brought funding streams from DWP and from social care together, were evaluated by a group of academics linked to LSE and the University of York as well as the University of Kent. They carried out a classic research study including randomized controlled trials and they published that research at the beginning of this year. What that research showed is compared with the randomized controlled trials the degree of satisfaction and improvement in outcomes and improvements in the quality of experience as reported by the individuals—to go back to Dr Stoate’s earlier question about outcomes—showed that those people who used an individual budget had higher outcomes than those who used more traditional forms of service. That was a published report and that was particularly noticeable for people with learning disabilities, people with mental health problems and people with physical disabilities. The evidence was less conclusive for older people but the sample for older people was much smaller.

Q102 Dr Taylor: When you said higher outcomes did you mean better outcomes or more expensive outcomes?
Mr Behan: No, the evidence was, although this was not statistically significant, that the individual budgets were cheaper than the more traditional forms of service, but the outcomes as reported by individuals in terms of their confidence and feelings of being in control were better. That is hardly surprising if you think about it; people with mental health problems who might think that control is taken away from them in a hospital setting when given control over their budgets feel in control of them. The evidence was statistically significant and that is now a peer-reviewed published piece of research carried out by independent evaluators of the success of that and that was individual budgets.

Q103 Dr Taylor: Where is that published?
Mr Behan: That was published at the end of last year.
Mr Bolton: About a year ago.

Q104 Dr Taylor: Moving on to direct payments, and I do not know if this is Jeff or David. They have been available for some time, take-up have not been particularly high; is personalisation going to lead to a higher take-up?
Mr Jerome: We think personal budgets will enhance that. Direct payments have been low but in fact they have gone up significantly. The last published numbers were about 90,000. Personal budgets can be taken either as a cash payment or direct budget, and you heard that earlier, or as a managed service which is effectively a variation of what happens now and which is managed by the council or offering a provider organisation to do that but in a personalised way. That is quite a big change for local authorities. Direct payments is not a big change, it has been around quite a while. There have been some slight changes to the guidance but in fact numbers have been going up increasingly on that side.

Q105 Dr Taylor: So they are going up and this will probably increase them?
Mr Jerome: Increase them.

Q106 Dr Taylor: Will there be any limit on what they can use it on if people take it in cash?
Mr Jerome: There is guidance that defines that but effectively it is fairly liberal. The main issue in terms of the law is that there has to be some connection between assessment of need and how that is being met. You can set that out, and that discussion on outcomes earlier was quite interesting, as a set of outcomes providing the amount of money that is allocated ultimately, either taken as a direct payment or personal budget, is reasonable to meet the set of needs. That is really what the law requires.

Q107 Dr Taylor: If their needs are just to get out and meet people?
Mr Jerome: If that is the identified need and it is a valid and eligible need, money could be provided for that.

Q108 Dr Taylor: So they could be used for anything that was moral or legal?
Mr Jerome: Yes, moral or legal.
Chairman: I am tempted to ask where the morality is but we will leave that for the time being! Doug?

Q109 Dr Naysmith: Following up what you have just said, Mr Jerome, I think part of the personalisation policy seems to have been to turn service users into micro employers and a number of concerns have been raised in different areas about this, including whether people can choose to opt out of doing so if they do not want to be an employer and whether the funding will be adequate for the service being sought, and the protection of both service users and employees from exploitation. Is each of these concerns legitimate and is there evidence that they are occurring? If so, how are they being addressed?
Mr Jerome: People can opt in or out of being an employer. They can take a managed service through the council or ask a provider to manage it on their behalf or employ people on their behalf. In fact, there are arrangements springing up where providers will employ people specifically or recruit people specifically for individuals or they can decide to take the cash and handle that themselves. What we are saying is that it needs to be legal, we are not saying anything more than that. There are all sorts of issues, I know and I have discussed that with the trade unions and with users, about the best way to approach some of the complexities about employment. A number of local authorities have set up umbrella-type support that will allow either payroll to be done or advice on national insurance, criminal records checks, etcetera, to be made available to people that will take some of the
pressure off them as employers, but there is not anything explicitly saying you have to go down a certain route of employment. It just has to be legal. **Mr Bolton:** Can I add something that might just help here. There are about 40 councils who now offer personal budgets as a matter of course, particularly to new customers, and the evidence we have from them is about 50% of customers are still taking the service as a managed service so they are still wanting the council or a third party to organise that. About a third of people are taking a mix-and-match approach so they want some services managed by the council but they want some of the money for them to manage themselves. That is rarely to employ somebody; often it is to do something they want to do with that money. Then about 17% are much closer to the direct payment where they are taking the money and that is the group that is likely to be employing somebody. That is holding up fairly consistently when I go round and visit councils.

**Q110 Dr Naysmith:** Is there any evidence of exploitation by firms coming in and exploiting individuals or of people being exploited? **Mr Bolton:** There are always cases you should worry about in any system and there certainly have been examples in direct payments before this policy came in of some risks and obviously we hope councils are carefully monitoring those people who they deem to be at risk and ensuring they have the right protection and safeguarding plans in place.

**Q111 Dr Naysmith:** Is there an adequacy of funding for what is expected to be purchased for particular sums? **Mr Bolton:** At this point in time the evidence seems to support that there are certainly no additional costs arising from this. Councils are reporting that they are able to deliver these services within the budgets available given the budgets have been stretched for the reasons we described because of demography, et cetera. It is not personalisation that is causing additional problems, as reported to us.

**Q112 Sandra Gidley:** Another question for Mr Jerome. Local authorities are going to be expected to shift their commissioning role towards stimulating and managing local markets of a number of competing providers, from which the service users will choose directly. You can make a parallel with the NHS where primary care trusts do that to a certain extent. We are also doing a separate inquiry into commissioning and there is a lot of evidence to show that commissioning in the Health Service is very, very poor. How can we be reassured that councils will do better? **Mr Jerome:** Than the NHS?

**Q113 Sandra Gidley:** That would be a starting point. **Mr Jerome:** Commissioning is a complicated term. The council responsibility in Putting People First is to make sure there is the range of care and support services there that individuals might want, so the immediate issue really is the broadening of choice because unfortunately just giving people a personal budget or cash does not broaden choice if the market response is not there. At the moment most of the evidence will be if you are not employing a personal assistant you are going to be taking a relatively traditional domiciliary care or even a residential care option, so what we are trying to do is encourage commissioning that broadens that choice and that is one of the milestone areas. The complicated bit really is that councils are going to need to stop thinking about themselves as the major holder of money in this and that is the balance that is there in personalisation and in personal budgets. A decision needs to be made about what councils need to collectively commission and how much people will draw off in a collective way from that even as a managed service and what they might be passing over to individuals for them to access the market. The council role therefore is to make sure in discussion with suppliers—and there is a big issue for suppliers here—that those services that people want are there. Going back to your earlier question about unmet need and want, some of the work that has been going on in the Department of Health around contracting has started to look in about half a dozen local authorities at what is known from what is not there, if you like, what is wanted, and to start to try and shape the market response by gathering that information and feeding it back to suppliers. The suppliers themselves of course have that information and that is an area we are trying to develop.

**Q114 Sandra Gidley:** The NHS has been quite directive towards PCTs. How much help are councils getting to make sure this is not a complete shambles like the original commissioning from PCTs was? **Mr Jerome:** We have a national work programme on which there is a major strand on commissioning and market development and market shaping. Some of John’s team at the Department of Health working with people on the local government side and in the regions are working particularly with suppliers and we are trying to have that interaction.

**Q115 Sandra Gidley:** How much liaison has there been with the people responsible for implementing World Class Commissioning? Are you learning any lessons from that? **Mr Jerome:** We are certainly having those conversations. The Department of Health has quite tight links. They are slightly different approaches though because we are starting from a completely different position and a lot of what happens in the NHS is procurement-based; this is a different concept.

**Q116 Sandra Gidley:** Is there any work being done to make sure that what is happening in social care and the changes to commissioning there do not clash in any way but rather complement what is happening in the NHS? Has any thought been given to that? **Mr Behan:** Again, Chairman, I feel that questions are being directed at Jeff that really should be coming to me and my team because we are in the
Department of Health and to go on to the theme from some of the earlier questions about accountability—

Q117 Sandra Gidley: To be fair this was about joint working.

Mr Behan: With respect, if I can just go back to the original questions about the concordat. This is the Government’s policy document Putting People First. It was a statement of direction of travel for the reform of the system. This is where the £520 million in three chunks of money is going into the system to reform the system. The delivery of this policy was built on a new model of delivery and we were trying to move away from a top-down model of implementing change of “government knows best”. Consequently the back of this document is signed by over 16 organisations, of which ADASS is one and the Local Government Association is another, and in delivering this strategy we had to reflect on how does change occur at a local level, particularly going back to your question, Chairman, about how is social care different from the NHS where there is not a command and control structure. There is not a Chief Executive of Social Care. It is a largely distributed and pluralist system where each of the 152 local authorities is a separate legal autonomous body in its own right. Arguably, the Department of Health’s job in relation to local government is to set out the direction of travel, the vision for care, and the signatures on this particular strategy are from the Local Government Association and from organisations such as the Association of Directors of Social Services, where they said we think this is the right vision, we think this is the right direction to reform social care services, and we sign up to working with you to change the system to deliver that vision. Going back to your question, Chairman, the Department is accountable to the Secretary of State for the delivery of that vision. The way that we have chosen to take that vision forward is by a consortium which brings together the Local Government Association and the Association of Directors. John chairs that programme board and the money which pays Jeff’s salary goes to the consortium so Jeff can be employed to work locally alongside local authorities to introduce those changes. So we are trying to move away a top-down approach and we are trying to build the capacity at a local and at a regional level to introduce these changes. This is less about “government knows best; please do what we tell you to do” and more about how can we grow the capacity at a local level. The accountable questions, Chairman, I think are rightfully pointed at the Department and the work about delivery and implementation are taken forward by John, accountable to me, accountable to the Minister and the Secretary of State, but with Jeff working alongside local government colleagues, the voluntary sector and the private sector at a local level on how we take these changes forward. It is largely about innovation that will take place in local authorities, in local partnerships and in local systems, and what we need to do is draw on those, but the accountability is through me to the Secretary of State.

Q118 Sandra Gidley: I think the problem is it is all very well saying we do not want a top-down approach and many of us would applaud that, but parallels in the NHS have shown that some help and guidance and assistance is needed. It is not necessarily didactic. I have heard the word “tool kit” sitting here more times than I care to think about. My question is really about what help is being given or is there any help being given to help councils do this or are they just expected to be imaginative?

Mr Jerome: The answer to that is there is a lot of help from the central programme. In fact, every single joint improvement partnership in all the regions has a commissioning programme. We are trying to link that to the national programme and we are trying to make sure there is no duplication and repetition. I was really throwing it across to the Department of Health side, particularly around the World Class Commissioning work which I know also has a central stream to it and I was inviting John whether he wanted to come in around that.

Q119 Dr Stoate: Mine is a fairly straightforward question and that is obviously local authorities can be bulk purchasers of services and therefore presumably get much better prices. What can we do to protect individual purchasers to make sure they are not disadvantaged?

Mr Jerome: A number of local authorities are saying to providers that they would like them through the different agreements they have—although this is a very tricky area—to offer, and in fact sometimes requiring it in a contract, and I have some difficulty with that I have so say, that they should sell privately in the same way that they are selling to the local authority. I say I have some difficulty because the providers do not like that at all.

Q120 Dr Stoate: No, of course they do not.

Mr Jerome: And I am getting my ear bent quite frequently about it. We have a lot to work through on this contracting basis. I have come across quite a few situations recently where through the contracting approach local authorities on the grounds of efficiency are requiring individuals to transfer care from one provider to another and I think there is a problem there in terms of the philosophy of choice. We have to do some thinking around that. Where does efficiency hit choice when we are putting forward a policy objective? I have had a few conversations recently with local authorities around that. We have to try and work out the best way of approaching that. It seems as if the concept of framework agreements, which is where you might accredit or list providers in a particular area and the requirements of quality et cetera, will be the way forward rather than concepts that are linked to cost and volume, but there are issues there around efficiency.
Q121 Dr Stoate: It certainly has not worked in terms of residential care because self-funders pay significantly over the odds compared to local authority purchasers.

Mr Jerome: That would depend on the arrangement with the individual providers. As you know, there is evidence of that in places. Again, it depends how a local authority as a purchaser works with the provider and how the provider then chooses to sell through the private market and all those arrangements are different.

Q122 Dr Stoate: My point remains though that in the real world self-funders end up paying a lot more than local authority funders for what looks like pretty similar care.

Mr Jerome: Generally.

Mr Bolton: Can I help here because this is something we have looked at. Interestingly, despite the evidence—you are right—about the disparity in potential costs in residential care, the evidence in domiciliary care is not the same. The evidence is that it is probably marginally pretty well the same. It varies according to the deal the local authorities got. If you talk to providers about that, they will suggest that they need to put a considerable hike on the cost of a contract with a local authority because of the bureaucratic requirements that the local authority place on them. At present we are looking at a scheme that might help them through using an electronic monitoring scheme and some software which software providers have developed to help do that which might reduce that, but actually at this point in time there is no significant evidence in the domiciliary market of a significant hike up of price, just so you are aware of that.

Q123 Dr Stoate: That is useful. Just a final point again to Mr Jerome and that is: is there much scope for personal funders to get together in consortia and purchase effectively in bulk themselves?

Mr Jerome: There are examples.

Mr Bolton: There is quite a lot going on on the Internet and other places. The whole purpose of this programme anyway is to try and get self-funders and public funders alongside each other in a market situation rather than what has been the case up to now which is really that self-funders are out there on their own. Through some of the universal support and advice that we have talked about earlier and through increasing use of Internet and other approaches and local community organisations, to assist people to do that, we are moving in that direction.

Dr Stoate: My main point is to ensure that individuals are not disadvantaged compared to other users. I have some reassurance now that at least that is being addressed. Thank you for that.

Q124 Charlotte Atkins: Mr Jerome, can you explain the principle of preventative social care and early intervention because this does not seem to have always been part of the social care package?

Mr Jerome: I will bring John in on this again in a minute because he is very expert in this area, but in thinking about universal services the thinking is that in all communities there will be a preventative and health improvement type of approach of inclusivity. As an ideal, local authorities with their partners will be trying to create that. There are a number of aspects to that around employment, education, transport, suitable housing, and information and advice as well as good health improvement programmes, so that is a general starting point. That goes back to the earlier discussion about how you keep people as healthy as possible. Added to that there are issues about what sort of targeted intervention programmes you need around rehabilitation, recovery, et cetera. That is seen as a main part of the operating model we are now trying to push forward which is a more individualised approach than that collective stuff I was just talking about, so it would be part of an expected operating model for us to look at individual need. This will be both people who are likely to fund themselves in the current model as well as those people who get a council personal budget. We would look at individual need and assist people to identify whether there was any potential for them to improve well-being and independence and there would be targeted programmes. I would like to come back to the fact that we still need to bear in mind that high numbers of people in this care and support service are towards the end of life so there are two aspects to this and it is not always going to be suitable.

Mr Bolton: Obviously as a department we are looking a lot at this area and I accept it has been a grey area in social care as to what the evidence really is about what prevention is. We tend to use the word to cover a whole range of things, some of which probably do not prevent anything. We start at the end of well-being, as I call it. Are people happy? Do they have the opportunities? Do they live in communities where activity goes on and they can have fulfilled lives, whether they have disability or old age? There are those kinds of services. The POPPs pilots, in particular the older people’s pilots, of which we are about to see the final results, has been a major study into the impact on people of those kinds of schemes. I think the evidence is going to show us they have a particularly positive impact in reducing people’s need for healthcare.

Q125 Charlotte Atkins: What sort of schemes are we talking about here?

Mr Bolton: They tend to be older people undertaking collective activities together. That would be a characteristic of that.

Q126 Charlotte Atkins: In a range of settings?

Mr Bolton: In a range of settings, yes.

Q127 Charlotte Atkins: You were talking about evidence earlier. What evidence is there of both the cost-effective of this and the effectiveness in terms of health?

Mr Bolton: That is what these pilots, which have been running now for two years and have just concluded, and the research is just putting that together, and that is going to be available to us in the coming months. I think it is due to be published in December.
Q128 Charlotte Atkins: Is it particularly elderly people doing things together?

Mr Bolton: That has been particularly focused on elderly people.

Q129 Charlotte Atkins: What sort of things have been piloted? Doing things together, what, going on holiday?

Mr Bolton: Social activities, engagement in community activities, engagement in activities, getting information and advice, running things themselves, being active citizens. There is a range of schemes that have been developed by older people for older people.

Q130 Charlotte Atkins: How does this work in with the personalisation and preventative approach? How do the two work together?

Mr Bolton: That is the beginning of the spectrum on prevention. The second area of prevention is the understanding that there are things you can do that can either stop people needing a service or defer the need for a service. We talked about the importance of when people come out of hospital, for example, that they get the right recovery programme to help them get back on their feet and not end up staying in a state of ill-health. There is evidence of what we call in our jargon reablement, which is a promotion of independence model, which actually helps people get back on their feet. There is very strong evidence that people will recover if given the right kind of treatment and help, particularly from occupational therapists and physiotherapists but also through staff who may not have those professional skills but who are supported by those professions and they can actually support people to regain their confidence and regain their independence. That can be a big thrust for older people in making sure they do not enter the care system when they do not need to because we can get people back on their feet.

Q131 Charlotte Atkins: An obvious scenario would be where someone has had a stroke and they need to reintegrate into the community. If we are going down the avenue of personal budgets and personalisation and so on, how would people choose perhaps to go to a good day centre or involve themselves in some sort of community initiative, but particularly how will they buy into that because we have focused in this evidence session very much on people employing or having other people employ personal assistants and so on. How does that relate to buying services which are provided either by the local authority or by a voluntary organisation?

Mr Bolton: I think it starts by actually seeing that there are services you can provide for people well before they get to the stage of considering a personal budget. For the kind of prevention and early intervention we are talking about, which is an aspect of personalisation, where most people would if they possibly can like to retain the independence of their lives as the way they express their choice, it is actually ensuring people have the right services and the right environment. We recognise the housing in which people live and having the right aids and adaptations (and in this day and age the new technologies, the telecare products, that are available for people) all of which can keep people outside of the care and support system where you might get a personal budget. Our prevention and early intervention strategies are focusing on how do you help those people who do not need to be in the care system remain outside it and to retain independence and have fulfilled lives in a suitable way.

Q132 Charlotte Atkins: We are really talking about quite a long time-span. We are talking about pre-personal budget needs and then we are talking about people who perhaps because they are vulnerable do not find it so easy to go along to the local pub or whatever and enjoy a social life and therefore they need a more sheltered environment where they can enjoy social interaction. What worries me about the personalisation agenda is that personal services are delivered to the person concerned or the person concerned is taken out to do things, but it is very much a one-to-one delivered to the home so they spend 24/7 at home not really interacting with a whole range of people. How can you reassure me that the personalisation agenda is not about that?

Mr Bolton: I think the context of Putting People First starts with the kind of society in which people live. It starts with a message about what it is that is available in the community and it only ends in a sense with social care. Part of what we are trying to achieve is that the towns, the cities, the villages in which people live are actually contributing to the kind of offer, as it were. Some of the best examples we see are in places like Herefordshire Council where they are investing in their village halls. That has enabled older people who might otherwise have gone to the day centres in the past to re-engage with their own communities using the activities in the village hall as a mechanism. That is how they have spent their personal budget to get to the village hall rather than to sit and wait for the council’s transport to take them to the nearest town to go to a day centre which may or may not have the activities going on that they wanted. That to me is a really good example of personalisation. It is the community and the individual coming together in the same way.

Mr Jerome: I would take you back to stroke for a second because the crucial area is what is collectively there for people in terms of the universal offer. I think part of that is health. I say this because the whole first year of my working life was in a stroke unit and there was a time when people stayed in hospital in rehab/recovery for three months or longer after a stroke. That is not the current approach, so the thinking has to be—and this is where it goes back to that joined-up stuff between health social care earlier—there have to be community-based programmes between health and social care with health funding around trying to maximise independence for people. If you took stroke, it would be clear programmes that worked with people in their own homes to maximise their
independence which is part of that collective investment, part of the universal offer, part of which is the Health Service, before you come to a view about what their individual pot of money through a personal budget for long-term care and support needs would be. With strokes some people can recover quite extensively if they have the right sort of rehab which will mean that their care and support needs are much fewer. That has got to be joined between the NHS and social care and particularly the NHS has to look much more strongly at its role in that area.

Q133 Charlotte Atkins: You mentioned universal services. Can you explain how that works and how that relates to creating social capital and how that all fits into personalisation and the Social Care Transformation programme?

Mr Jerome: The thinking has to be if we are going to keep people at home and in their communities with their families, supported by these sorts of things, particularly those ones that are collectively invested in for groups of people, that you can build around individual family and community input. There are examples of that in different ways through the different sorts of social enterprises being created and through different arrangements for family support, and particularly where you give people a personal budget or individualised care and support programmes, you can then build family and community environment around that. That is completely different from where you say to people you have to take something from a contract; it is only delivered in this way. It starts to build around individual need and aspiration. There are at the moment things more on the fringes around that, things like time banking and credit unions that can still input into that.

Q134 Charlotte Atkins: What is time banking?

Mr Jerome: That is a bit on the fringe but with people with learning disabilities or older people who have something to offer people, there are some good examples of where they are able to perhaps support an older person but gain a credit through a time bank concept in a community so they get something as an older person but gain a credit through a time bank example and there are 16 time banks for example in Essex where somebody with a learning disability could go and work and do some gardening or some cleaning or some work with an older person and gain a credit so it gives them some sort of employment concept as well. There are examples out there.

Mr Behan: If it helps, I have two specific examples. You were asking John earlier about prevention. One of the pilot schemes that I have visited over the past 18 months is the Dorset Partnership for Older People Pilot for older people in that rural county of Dorset who are housebound—so the point you are making about isolation is a powerful one for many of them—and the way that the Dorset POPP works is that it brokers a relationship between other older people who want to be volunteers who visit the isolated older people in their own homes. In the visit that I made I met both the people who were being visited and those people that were doing the visiting and that was an example of how the community, largely based on the villages in Dorset, was operating to support people, and it builds on the example that John gave.

Q135 Charlotte Atkins: Can you give us a concrete example of where this is working? There are all sorts of theories and what I would like to know is where it is working, where has there been a positive difference by creating universal services which people could really buy into? I have to say from my experience you have personal assistants very often who are taking out young people with learning disabilities every day of their lives, which might be great for some young people but not great for other people, and they find themselves going out in the community but not really integrated in any way and being quite isolated because all they have is a relationship with their personal assistant and they are not having a relationship with the community or indeed with youngsters of the same age.

Q136 Charlotte Atkins: Let me make it clear, I was not talking about people being house-bound; I was talking about the fact that with the personalisation agenda services are delivered very much to the home and rather than people going out, they are actually having the services delivered to their home and therefore are not involved in the community, whether it be a day centre or their local community because the services get delivered to them. That is what I was talking about.

Mr Behan: I think it is a completely legitimate challenge. I would want to argue that that is not about personalisation. Our argument would be that personalisation is just as much about what happens in a group living setting, in sheltered accommodation and for people who live in residential accommodation. Personalising care around individuals, whether they are living in their own homes, attending a day centre or in a residential setting, is key to the policies that we have been pursuing. A personal budget where somebody chooses to use it, as John has said, is actually used by a number of people but our policy of personalisation applies to all people. On the issue around isolation we have been attempting to address the notion of social capital and I thought you were challenging us
to give some practical examples of how people are coming together to use the capital in communities to support people so they do not become isolated. My offer of the Dorset POPP was not disputing the fact that isolation is a key issue. Arguably, isolation and anxiety is one of the great challenges of the next few years that we need to address. I do think it is a particular issue that we need to address but the concept of social capital making a contribution to the way the communities can provide care and support to individuals and to groups of people is one that we want to encourage. There is a variety of different ways that can be developed through 1970s community development ideas, working with John’s example from Herefordshire about using village halls, and they are all examples of how people are beginning to think creatively and laterally about the contributions people want to make. On the issue of social contribution, I think many people who have got to retirement age who are in their late 50s or early 60s will still want to make a social contribution. They may make that through volunteering or through engagement in the governance of voluntary organisations at a local authority. There are a thousand different ways that people will make that.

Q137 Charlotte Atkins: If you have a personal budget, you can spend that budget on anything you want, including services provided by a council or a local volunteer organisation? I know with direct payments there have been issues about you cannot use them to access a local authority facility.

Mr Jerome: It is a managed service on the council side. You will be told what your budget was and you would be told the cost components that were making up that budget, so if you are using council services what you really need to do is to see an account that tells you what the cost components of what you are getting from the council are. The council is still holding the money rather than giving it to you because there still is a provision to buy a service from the council but it is the same concept. The big issue, frankly, is that councils are going to need to understand their cost components and in doing so individuals will see whether that looks to be good value for money or not—those individuals who are able to do that—and that is quite a big change for the public sector.

Mr Bolton: I could give you quite a lot of examples if you wanted me to. I wanted to get the principle across. What I have seen is that this one-third I described who want to take some of the councils’ managed service and use some of the money themselves, quite commonly it is not new commissioning they are looking for, it is access to the existing services in the community. I can remember being in Doncaster recently and they said quite a lot of the older people were wanting to access things that were available in that community with their personal budgets alongside keeping the domiciliary care support that they also were getting. Staffordshire has very similar models. If you want a community activity go to the brand new sports centre in Sunderland where they have a programme to support people recovering from mental ill-health or who have learning disabilities to join in sporting activities with other people. While I was there there were some mental health service users engaged in some swimming activity which was going to support their engagement with that pool. We might be on the edge of it but we are beginning to see some really creative, much more imaginative use of the money in ways that both links to the community, builds on the social capital but also contributes to the massive raising of opportunities for people within social care.

Q138 Charlotte Atkins: How are you suggesting that Staffordshire is doing it differently?

Mr Bolton: I was particularly struck by Staffordshire in talking with their social workers because they felt freed up to work with people on creative solutions to the problems they faced in which they were massively encouraged by their council to look at the community offer as part of that solution.

Q139 Charlotte Atkins: I cannot say I have noticed. But anyway, can I just ask you about people who do not qualify for local authority support who have to fund themselves. What can they expect from personalisation and from the National Care Service?

Mr Bolton: I think we have covered those issues. The universal offer that we talk about ought to be available to self-funders. I suppose the big issue is getting the right information and advice so they make informed choices about how they want to spend their money, they know what is available to support their care needs, and they have access to programmes like the intermediate care reablement programme, so when they have been ill they also get the whole range of those preventative options open to them. That is the kind of direction, to make sure, as Jeff said, that they are a part of the system because in a sense in the new system at one level everybody becomes a self-funder and how you get them to work together using that is part of the challenge.

Mr Jerome: A simple one liner which colleagues said recently is they would expect to get support to make what would appear to be the right decision around care and support services, irrespective of whether they are going to be paying for them or are getting some sort of contribution from the public purse.

Q140 Dr Naysmith: I do not know who is the best one to answer this question. In both the Health Service and in social services the idea of joined-up services is used a lot and people talk about trying to achieve it. What would it look like in the sort of areas we have been talking about this morning? What are the obstacles to achieving joined-up services in this area?

Mr Jerome: I might give a slightly different view than David so I will hold back for a minute.

Mr Behan: If you looked at mental health services now you would actually see the vast majority of mental health care in this country is provided by joint teams which bring together staff from a social care background and staff from an NHS background and indeed in some of those teams you will have employment specialists and housing specialists designed to give that care. Similarly, a
significant proportion of care for people with learning disabilities is delivered by people in multi-disciplinary teams which will bring together nurses and social workers alongside psychiatrists and psychologists. We know from the work we have been doing on dementia over the past year that progress has been made in some parts of the country about integrated multi-disciplinary dementia teams. Particular progress has been made in the South West.

Q141 Dr Naysmith: What are the obstacles to achieving faster progress?

Mr Behan: The obstacles are around culture. They are about whether there is a shared vision. What we know about integrated services is that they are driven by leaders who share a vision, who trust each other, who are determined to make a difference at a local level, and who have a passion for bringing services together in the interests of people who use them. The obstacles that we need to address are about have we got the right leadership, have we got a clear vision, and is that vision being driven forward at a local level and indeed is that being supported at a national level? Are we sending the signals that say this is the right way to go? Again, what people have told us they want to see from services is services that are supportive of them. They are very rarely interested in who is delivering the service. What they are interested in is the fact that the service is being delivered in their interests.

Q142 Dr Naysmith: That raises a really interesting question. Is it going to be possible to get these joined-up services as long as there is a separate National Health Service and a National Care Service?

Mr Behan: What we know is there are many different ways of organisations coming together. As we have tried to suggest in our answers this morning, the interface between health and social care is desperately important. We talked earlier about the isolation of many people and initiatives like Extra Care Housing are fantastic initiatives which bring people together and provide that support in a social environment where people are free to make those decisions. The interfaces with housing as well as with health are key interfaces. Wherever you draw a boundary you include some people in and exclude some people out.

Q143 Dr Naysmith: Would it not be easier if they were funded and administered in the same way or is it going to carry on under the new system getting closer but not getting quite close enough?

Mr Behan: The vision that we have in the new system is that the systems will be drawn together and we need to build on the work that is already there. There are many tools that are currently available that draw services together but there is a strong signal in the Green Paper that we need to do more of this and this needs to progress more quickly.

Mr Jerome: There is still a big issue, and it goes back to that Green Paper debate earlier, about people's understanding of the two systems and particularly what they will and will not have to pay for. That is really very, very complicated when individuals are asked and do not always understand. As David and Alexandra said earlier, that is what comes out and it is particularly difficult around long-term conditions and long-term care funding. On the ground that is sometimes difficult for people to address and certainly just as a comment on the Green Paper as I was not part of that discussion, in any form of discussion with the public about a future service, people do need to understand more about the NHS than they need to understand about social care. They need to understand where the NHS starts and finishes and when they are outside of a free system. Not understanding that is partly what causes some of the difficulties in people's minds. I think sometimes the NHS is misunderstood more than what is in local government.

Q144 Dr Naysmith: We are beginning to bring in direct payments for healthcare, sometimes called personal health budgets; is that going to create greater opportunities for joining up the experience of people using health and social care services?

Mr Behan: It is our view that that will be the case. If you take people with long-term conditions, just to go back to your earlier question, I think those people particularly with long-term degenerative conditions will benefit from this opportunity of being able to combine a personal health budget and a personal social care budget.

Q145 Dr Naysmith: It is in those areas that there is not a lot of difference between the needs on the health side and the social care side because it goes on and it does not just stop. It is not like emergency care or surgery or something like that, it just goes on, so it is daft to have two different state systems trying to make sure these people are well looked after.

Mr Behan: Our vision is to draw these services together and it will be particularly those 15 million people with long-term conditions who require exactly that kind of support who would benefit from a closer relationship between those two services.

Q146 Dr Naysmith: It is good that you are all optimistic about it.

Ms Norrish: When you are thinking about integration you can think about it on a number of different levels. If ultimately what you are saying what matters is that the person who is receiving care experiences that as joined up, then that is one focus. If you say that what matters to you is having a single organisation, we know from experience that you can be in a situation where the organisations are very close or indeed identical and have pooled their budgets etcetera but still the individual who is receiving the care does not necessarily experience them as a joined-up service. The approach that we took in the Green Paper was to say that what matters most is the experience of that person and we have got examples all over the country of a whole range of different ways in which different local authorities have made it work for the person. If that means that they want to go down the road of creating a care trust, which is really aligning the two organisations
into one, they may choose to do so, but there are many other ways that other local authorities have achieved the same or better outcomes in terms of improving the situation for the individual, for example by setting up joint teams, by joint training of staff, whatever that might be, without going through a structural change. So personally I do not think that structural change is necessary in order to improve the experience of the individual.

Q147 Chairman: Jeff, could I just ask you what are the implications on the workforce of the Social Care Transformation programme?

Mr Jerome: Well, there are different aspects of the workforce. There are implications for local government about what sort of workforce is going to be employed, bearing in mind that in terms of the person-to-person support side of it, so the hands-on delivery of care, most of that is not in local government any more, most of that is delivered in the independent sector. The bulk of the consideration is the staff working around the universal area of information and advice and making the right decision and all of that and what is the right group of staff there. I think the bigger issue than that, and there have been discussions within that about the role of social workers, is the 85% of people who are going to deliver hands-on care and support, most of whom are in the independent sector and how do we create the right sort of strategies both to encourage people in but also to create a culture where there is a person-to-person responsiveness by the people who are delivering hands-on social care to that personalisation concept. There are some difficulties within that about the levels of training and skill. Part of the debate is how much do you train people up to work individually with people. Some people think the more you train people and the more professionalised something becomes the less receptive they can be to individual desire to work around a personalised service. All of those things are very important in the debate but we are developing and the Department of Health is developing a very sophisticated workforce strategy that will pick up those different elements, particularly working with the supply side because that is the bigger issue given the demographics about where you are going to get all these people to work in the sector.

Q149 Chairman: Is it going to be people who are independent providers who are going to have to satisfy some criteria in terms of the level of competence of their workforce or have we just got a document with good intent with all these names on that you read out? Is there going to be a mechanism where a workforce strategy is going to work beyond good intent?

Mr Behan: The Secretary of State sets the framework within which those organisations operate and that is why the workforce strategy for social care will look different than a workforce strategy for the NHS. Going back to the concordat Putting People First, what is really important is that the signatories to the delivery of this vision include people like Martin Green, who is the Chief Executive of the trade association for care homes. It includes Leslie Rimmer and Mike Padgham who are the Chairman and Chief Executive of the United Kingdom Home Care Association. The point behind that, Chairman, is that building this alliance of those leaders of those sectors is absolutely critical to the strategy we have to drive forward reform and improvement. Central to that is the work of Skills for Care—again co-signatories to the document. What we know in terms of the social care workforce is that the level of penetration of NVQ Level 2 into the workforce has increased year on year on year. There is still an awful long way to go in relation to this workforce in terms of their terms and conditions and the degree of training and qualification in the system but it is improving. What we need to do looking to the future, where the Green Paper anticipates an additional 1.7 million people will require care and support by 2026, is to develop and design the curriculum and courses to ensure the workforce have the skills required to provide that care. Hence the approach of a concordat in setting out the vision we have. This is deeply challenging and we do not under-estimate just how difficult it is to set a workforce strategy, but key to this is getting the leaders of the sectors aligned with the strategy and working with us and alongside us and not working against us in relation to this. An awful lot of effort by my colleagues here has gone into ensuring that we have those alliances so we can take this forward. We are not pretending that this is not difficult and there is a long way to go. The Audit Committee in Department of Health will continue to challenge on whether we have the right workforce strategy because obviously one of the key risks to the delivery of any policy is whether we have the right workforce strategy particularly where it is a largely distributed workforce with thousands of different employees.
imminently and I expect she will make recommendations about how that can be strengthened and developed and improved. Similarly in relation to the work that the Care Quality Commission undertakes there is a requirement that all registered services have workforce strategies which allow their staff to progress to the appropriate levels of training and qualification hence a target has been set in the past that 50% of all care staff need to be qualified to NVQ Level 2 and all managers of care homes need to be qualified to NVQ Level 4. That Level 4 qualification is achieved and currently NVQ Level 2 in care homes is about 60% to 65%. That is behind the year-on-year improvements that have taken place. It really is important that the regulatory framework continues to incentivise providers to attend to the development of their staff. There is a reputational issue however coming through. If you speak to some of the organisations, they know that they cannot afford for their reputation to suffer by being poor employers who do not attend to the training of their staff. So Methodist Homes for instance, which is a care group that specialises in the care of people with dementia, pay particular attention to ensure that their staff have training in appropriate degrees of care for dementia. They are probably one of the leading providers around this care and they have been able to get to that position by investing in their staff, so it is not just exhortation and leadership; there has to be a harder edge to the regulatory framework to drive this forward. 

Chairman: Could I thank all four of you very much indeed for coming along and helping us with this inquiry today. We will see what the next few weeks bring.
Thursday 5 November 2009

Members present
Mr Kevin Barron, in the Chair
Charlotte Atkins
Sandra Gidley
Stephen Hesford
Dr Doug Naysmith
Mr Lee Scott
Dr Howard Stoate
Dr Richard Taylor

Witnesses: Mr Raphael Wittenberg, Personal Social Services Research Unit, London School of Economics and Political Science and Professor Carol Jagger, Professor of Epidemiology and Director of the Leicester Nuffield Research Unit, University of Leicester, gave evidence.

Q150 Chairman: Good morning. May I welcome you to our next evidence session on our inquiry into social care? For the record, may I ask you to give us your name and the current position you hold?

Professor Jagger: Carol Jagger. I am Professor of Epidemiology at the University of Leicester.

Mr Wittenberg: I am Raphael Wittenberg. I should explain I have two posts: I am a Senior Research Fellow at the Personal Social Services Research Unit at the London School of Economics and Political Science; I am also an economic adviser at the Department of Health.

Dr Stoate: You have been referred to as a boffin already today.

Q151 Chairman: We had a discussion about what boffins are but it was nothing personal. May I first of all ask a question of both of you? Last week David Behan from the Department of Health told us that in 1948 life expectancy for men at birth was 66. He then said "so you retired at 65 and then lived for a year" and that was it, whereas today it is 77. Life expectancy at age 65 in 1948 was for a further 12.8 years, so in actual fact, if you got to 65, you were likely to live until you were 77.8 years old. Are we misled into thinking that changing life expectancy is having a much more dramatic effect than it really is?

Professor Jagger: Yes, I agree that looking at it from age 65 it is clearly the life expectancy from 65 that is relevant.

Q152 Chairman: Raphael, do you agree with that analysis.

Mr Wittenberg: Yes, I agree that looking at it from age 65 it is clearly the life expectancy from 65 that is relevant.

Q153 Chairman: Clearly core to social care is this issue of the ageing population. How much is the ageing of the population actually down to the bulge of people born in the post-war baby boom getting old rather than people living longer? There are quite a lot of us. Is this showing up statistically?

Professor Jagger: It is both. The post World War I baby boomers are now 85 and over. The post World War II baby boom was in fact bigger and they are coming now to be in the 65 age group and life expectancy has increased so that the cohorts in between there are living longer. There might be fewer of them but they are living longer. I do not think we can say it is something which is going to go away.

Q154 Chairman: And it is not just because there are more of them.

Professor Jagger: No, because the probability of survival to old age has risen as well quite considerably.

Q155 Dr Stoate: We know that people are likely to live longer and we know that life expectancy at certain ages is extending, which is obviously good news. What we do not know is the level of dependency that is likely to lead to. Just because someone gets older does not necessarily make them more dependent. What do we know about levels of dependency and projections on levels of dependency in the coming years?

Professor Jagger: Not as much as we would like. In this country we do not have any really good cohort data like some other countries such as Denmark and Sweden have. We are in the process of getting that; there is a study in the field at the moment which will address that much better than we have done before. However, there does not seem to be any indication that the years of disability are reducing very much. Clearly core to social care is this issue of the ageing population. How much is the ageing of the population actually down to the bulge of people born in the post-war baby boom getting old rather than people living longer? There are quite a lot of us. Is this showing up statistically?

Q156 Dr Stoate: You do not subscribe then to the "compression of morbidity" theory?

Professor Jagger: No. I do not for this country. The data we have is rather mixed. Do you want me to say something about what I mean by "compression of morbidity"?
Q157 Dr Stoate: Yes; for the record.

Professor Jagger: “Compression of morbidity” is really looking at the relationship between life expectancy and healthy life expectancy and how one is changing with respect to the other. As an example, male life expectancy in 2001 at age 65 was 16.1 years and disability-free life expectancy was 8.9 years, life expectancy with disability was 7.2 years. By 2005 life expectancy had risen by one year (to 17.1 years), disability-free life expectancy had risen by 1.3 years (to 10.2 years). So the years with disability had reduced by 0.3 years and that is a compression of disability. The same was not true for women. For women, the years with disability had increased, despite the fact that life expectancy had increased and disability-free life expectancy had increased because disability-free life expectancy had not increased as fast as life expectancy.

Q158 Dr Stoate: Do we not know why it does not apply to women but it does apply to men?

Professor Jagger: No. Women have more disabling diseases and so in most studies in most countries women have a higher prevalence of disability than men.

Q159 Dr Stoate: Do you know much about the relationship between future levels of dependency and key health conditions such as coronary vascular disease, stroke and cancer? Do you know anything at all about how those are going to play out?

Professor Jagger: Coronary heart disease rates and the mortality from coronary heart disease are reducing. The incidence is reducing somewhat as well. The mortality from stroke, which is another disabling disease, has reduced considerably since the 1950s. There is some evidence for coronary heart disease that the rates in some younger age groups are levelling off but all that means is that we are keeping more people alive who have the disease as opposed to actually stopping people having the disease to begin with. More people are living with disease now.

Q160 Dr Stoate: Do we know much about things like time bombs, things like obesity, epidemics, alcohol-related illness, because those are clearly changing in society? Do we know much about the future effects of those?

Professor Jagger: Obesity does not have a huge effect on mortality; it has a much greater effect on disability. The obesity rates are rising, though I understand that in children they have started not to increase as much recently. That will certainly have an impact on dependency but it will not reduce life expectancy particularly.

Q161 Dr Stoate: I do not actually agree with that because evidence I have seen is that obesity reduces life by about nine years. We are now likely to see people predeceasing their parents with conditions such as diabetes and heart disease as a direct result of obesity.

Professor Jagger: That has not been the case in America, partly because people with obesity are more closely monitored than anything. Certainly at older ages it is not true. It might increase premature mortality somewhat but by the time you get to 65 some degree of overweight may be protective.

Q162 Dr Stoate: You are presumably talking about the over-65s. It is estimated that one quarter of smokers, for example, do not reach 65 so I suppose you do not look at those so much.

Professor Jagger: No, I am not looking at those so much. What I know most about is the older population.

Q163 Dr Stoate: Do you have any possible projections of things like pandemics such as pandemic flu? Have you done any modelling on how that might affect prevalence?

Professor Jagger: No, not to my knowledge is there any modelling on that at all and I do not think we have the data, to be honest.

Q164 Mr Scott: Could you tell us what the Government could do, particularly through public health interventions, to reduce the need for long-term care services in the future?

Professor Jagger: I would say concentrate more on alleviating the disabling effects of disease rather than reducing mortality from disease. A measure of the efficacy of many clinical trials is mortality rather than disability so we do not really have a good feel for how some of these treatments like statins are improving daily life for older people. We know that they are reducing mortality and they are reducing secondary strokes or coronary events but we do not know how much they are improving daily life.

Q165 Mr Scott: Do you think that is something we should certainly look into in greater detail?

Professor Jagger: Yes, it would be useful to be able to have some idea of how much treatments that are coming in are reducing disability and allowing people to remain independent longer. Also, we have to make sure that treatments are getting to everybody who could benefit because there is good evidence that certainly women and the very old are not getting treatments that they should.

Q166 Mr Scott: What about intermediate care?

Professor Jagger: Yes, obviously it would be helpful if people were allowed to develop services which would benefit them more than having formal services that everybody had to fit into. I certainly think that would be helpful, yes.

Q167 Sandra Gidley: It surprised me that you said women were not accessing or receiving treatments. Generally they access health services better than men and there is a lot of evidence for that. Are you actually saying that they are accessing maybe primary care but then being denied treatment and there is sexism in the system or does something go wrong when they get older?

Professor Jagger: It is particularly the evidence for statins because coronary heart disease is not as well diagnosed in women as it is in men.
Q168 Sandra Gidley: Apart from statins is there any other evidence?

Professor Jagger: No, I do not think so.

Q169 Sandra Gidley: You made quite a sweeping statement there.

Professor Jagger: I did but it was in a particular treatment so I am saying that there are people who do not get treatments that they would benefit from and women and statins is one example.

Q170 Sandra Gidley: To be clear, one example is women and statins; that is just one example and not a generic situation.

Professor Jagger: That is the case.

Q171 Dr Naysmith: Mr Wittenberg, we have heard quite a lot about statistics and the demographic aspects from Professor Jagger. Can you tell us what other factors, in addition to the ones we have just been talking about, are likely to affect future long-term care expenditure? What are likely to be the pressures on expenditure for long-term care?

Mr Wittenberg: Looking at the pressures on long-term care expenditure, I imagine one wants to concentrate it in the first place on the demand side. Clearly what is actually spent will also be a function of what money is made available, so I assume it is mainly the demand side that you are asking about.

Q172 Dr Naysmith: Yes.

Mr Wittenberg: The demand side is affected by the numbers of disabled people in the future. Other issues to be looked at in the modelling I have been involved in, for example, are the household composition of older people, particularly the proportion projected to live alone. Very closely linked up with that are issues around the supply of informal care, that is how many older people will have a surviving spouse who might provide care or surviving adult children, for example, who might be able and willing and living near enough to provide care. The whole social side in a sense around household composition and informal care is very important. Whereas the expectations around the quality and types of care and the quantity of care is another big issue, that is clearly a speculative one.

There is a view that expectations of future cohorts may be higher but I am not aware of one particular measurement of that. Economic factors may be relevant as well, issues around the wealth and the pensioner income of future cohorts of older people in two senses: they clearly would affect the means test, since we have a means-tested system; obviously future incomes and savings affect the numbers eligible for publicly funded care but may also affect overall demand if people's preferences for care in any way related to economic considerations.

Q173 Dr Naysmith: These are fairly diverse things we are talking about. How easy is it to estimate them and bring them into models of future provision? Some of them depend on all sorts of things over which we have no control.

Mr Wittenberg: I agree; some of these factors are difficult to look at and it means there is a range of uncertainty around the estimates. You remember that the Royal Commission talked about a funnel of doubt and had a diagram opening up a wedge of different projections; that was a very good phrase in a sense to have used. I should also have mentioned earlier the unit costs of care which are another area of uncertainty. As far as the household and informal care areas are concerned, projections of household type are produced from time to time by CLG, which are available and one of my colleagues at LSE, Linda Pickard, has looked into the area of projections of informal care. Again, one has to make assumptions. Her base case assumption really is that the propensity to provide informal care is constant, that is to say that if at a given age, gender, educational attainment level X% provide informal care to their parents, then one way of looking at it is to say “Let’s assume X% remains constant over time”. Of course it may not do. So there are ways of looking at building up scenarios in some of these issues but of course the future is uncertain and with informal care being dependent on employment-related issues and geography, where people live, which in turn may be related to employment, makes it a very difficult area.

Q174 Dr Naysmith: I imagine quite a lot of informal care is actually people who are caring because they cannot get any help from anybody else to do the caring. Is that not the case and if there was better provision there would be less informal care?

Mr Wittenberg: The issues of the linkages between formal and informal care is another complex area. For example, we have looked at data from the General Household Survey and certainly it is the case that after controlling for people's age and disability, taking that into account, people living alone are more likely to get care than, say, a married person living with their spouse or a married couple getting help from adult children. Yes, it is possible in theory to imagine a system that was carer blind and I think that Denmark has such a system. If there were more care, in theory that could be done but it would clearly use resources and the question then is where one wants to concentrate resources.

Q175 Dr Taylor: Continuing that line, may I try to tie you down to some estimated figures? From the modelling work you have done, can you tell us how many older people require long-term care at present? Is that known?

Mr Wittenberg: I can tell you about the numbers who receive long-term care at present and I can tell you something about the numbers of disabled older people in the community.

Q176 Dr Taylor: The number receiving.

Mr Wittenberg: The numbers of older people receiving are probably roughly 300,000 in care homes; a bit of uncertainty because we do not have hard data on either the NHS funded group or the privately funded group but it would be of the order of 300,000, which is less than 4% of the older population.
5 November 2009  Mr Raphael Wittenberg and Professor Carol Jagger

Q177 Dr Taylor: But you do not know the number struggling at home with informal help and somehow managing.

Mr Wittenberg: We have some estimates of the numbers of older people receiving informal care and I think that in our work we found roughly 1.75 million out of two million disabled older people in private households, excluding the care home group, receive informal care. This is obviously dependent on survey information extrapolated from the General Household Survey on particular definitions of disability and informal care. It looks as though a very considerable proportion of older people who are disabled receive informal care and it is mainly from a spouse or an adult child.

Q178 Dr Taylor: I find that 300,000 a much smaller number than I expected. Does the modelling give any idea how this is going to grow in the next ten years or so?

Mr Wittenberg: Yes. May I just explain that we have been working with various models at the PSSRU. The aggregate model certainly looks separately at the growth in the numbers in care homes and the numbers in the community. However, the only way of doing this is to make assumptions about future patterns of care. One way of looking at it is to say “Let’s assume that the balance between residential and home care and indeed the balance between formal and informal care is constant” but clearly this is a policy variable and, as you know, there has been a longstanding policy to promote care in the community rather than in care homes. Taking that into account, it clearly depends on the success of the policy and the wishes of future cohorts of older people. So it is not possible to give a categorical answer.

Q179 Dr Taylor: So you are saying that the ratio at the moment is 1.75 million to 300,000.

Mr Wittenberg: The 300,000 in care homes and roughly 1.75 million receive informal care. What I have not given you yet is the formal care in their own homes. The latest data is that about 650,000 are receiving publicly funded home-based care, day care et cetera. An estimated 150,000 severely disabled are receiving private home care, but again one has to be rather cautious about the private care numbers as to whether they are quite right or not. There may be people in both but that would suggest something like 800,000 disabled older people in the community receiving either publicly or privately funded home care. Of course a lot of them may receive informal care as well, there will be an overlap.

Q180 Dr Taylor: So it gets more complicated by the moment, does it not?

Mr Wittenberg: Yes. In the model in which I have been involved we try to look separately at different groups and think about the overlap but yes.

Q181 Dr Taylor: Is there any way of forecasting how much costs are going to go up?

Mr Wittenberg: Certainly we do that although we do emphasise that we are not producing forecasts in the sense that there is clearly no way of being sure what is going to happen let alone people’s expectations and wishes. What we do is to produce what we call projections. That is to say that we say “Supposing X, Y and Z, then how much would expenditure be?” That is basically the approach we take. For example, in the modelling which has been done for the Green Paper and earlier modelling, we said, “Let’s assume the numbers of older people go up in line with the official ONS population projections. Let us assume that the pattern of care remains the same, that the probability of people with some particular characteristics receiving care is constant. Let us also assume that the unit cost of care, that is to say the cost of an hour’s home care, rises by 2% a year in real terms” or an alternative can be looked at. On that basis, yes, we have produced projections and we produced them originally for the Royal Commission for a whole lot of different government agencies and the EU since then.

Q182 Dr Taylor: What is the margin of error?

Mr Wittenberg: It is not possible to give a statistical answer to that. It is not as though one were just looking at, say, the confidence intervals of a particular survey. Of course those exist, it is really that one has, with each of these parameters we have been talking about, the numbers of older people, disability, household composition, unit costs, to think what the plausible range is in each. Then you either vary them one after the other, which is what we have done, or you take all the scenarios. We try to look at a minimum and a maximum; the range is great and the biggest factor is the uncertainty about unit costs because clearly our base case at the moment is to assume unit costs rising about 2% a year in real terms but that may be rather high.

Q183 Dr Taylor: We are coming on to unit costs. One encouraging comment was from Professor Jagger that some degree of obesity is protective in older people. As somebody with a BMI above where it should be, I find that very reassuring.

Professor Jagger: Overweight rather than obese.

Q184 Sandra Gidley: I just want to pick up on unit costs. You said that they would be increasing 2% a year in real terms. Can you clarify the reasons for saying that? Why is it not just in line with inflation? Is it more people or are there actual costs? No, if it is unit costs it is the cost per person.

Mr Wittenberg: Actually by unit cost, let us say of home care, I mean the cost per hour. Home care is very, very labour intensive. In general terms—we are not talking about the next couple of years but well ahead—the Treasury have assumed that productivity and average earnings will both rise by 2% a year in real terms. This is for very long-term projections over the next 50 years and we have taken that as our base case. Of course that may not be the case and there are lots of reasons why it may not be. Particularly if one uses the 2% assumption and particularly assuming that the average earnings of
care staff will go up in line with the average earnings of the labour force generally, that may not be the case. I have seen people arguing it both ways; some say care staff earnings might rise faster and that could depend on future policy on the national minimum wage, for example. So it is partly policy related. Another view is that because the qualifications required are not very high and there may be fewer jobs over time for people with lower qualifications, the earnings of this group may rise more slowly. There are also issues about expectations. Obviously if quality of care rises, that may or may not affect the unit costs.

Q185 Sandra Gidley: Basically you do not have a clue by the sound of it.
Mr Wittenberg: There is no categorical answer. We can look at past trends and clearly the real unit costs, particularly of care home provision, have risen but there may be other reasons there as well. It is difficult. Sensitivity analysis is wise and in the short term, given the present state of the public finances, one might reasonably question whether 2% was too high and perhaps the short term and the long term may differ.

Q186 Sandra Gidley: You also have a demanding baby-boom generation coming up who may be demanding improved services. Do you not think that is likely as well?
Mr Wittenberg: Yes and there has been quite a lot of commentary on that and the general view, from what I have read, is that is likely, although I have to say that with home care that is more likely to affect the numbers of hours per week perhaps than unit costs. With residential care of course it could affect the weekly cost in terms of the facilities of the care home.

Q187 Sandra Gidley: What is going to be the impact of personalisation on the unit costs of long-term care services?
Mr Wittenberg: There are two possible issues here. Talking again about the cost of one hour’s home care, what one might suppose is, if block or bulk purchasing by councils, some of whom have quite a bit of a monopsony power, that is to say they are the only big purchaser in their area, that replacement of that by lots of individual micropurchasing might give providers the opportunity to raise prices through the diversification of purchasing. There may be ways of handling that and it could be that people could come together and purchase collectively or the council could help them do that. There is a possibility of rising unit costs from that source. Part of the evidence would be from the care sector where it is well known that in general self-funders seem to be charged more than the local authority pays. There is one set of issues about unit costs in that sense of the word. There is another set of issues about whether the weekly care costs would be higher for people receiving personal budgets, let us say, rather than people receiving conventional services and that is something that the evaluation of the Ibsen project examined. There is the second question as to whether the weekly care costs will be different under individual budgets, now personal budgets, from conventional packages of care. That is one of the issues addressed in the evaluation of the individual budget pilots in which the PSSRU and others were involved. They found no statistically significant difference, as I understand it, in the average weekly cost between the sample who were receiving individual budgets and the control sample, the comparison with people who are not.

Q188 Sandra Gidley: Were the individual budgets higher?
Mr Wittenberg: No, there was no statistically significant difference.

Q189 Sandra Gidley: Sorry, I thought you said they were higher.
Mr Wittenberg: There was no statistically significant difference as I understand it.

Q190 Sandra Gidley: Would high rises in unit costs impact on the suitability of the different funding systems in the Green Paper?
Mr Wittenberg: I am just thinking whether there is a link between those two matters. Personalisation could apply on any of the funding systems in principle and therefore the issue of whether personalisation would increase unit costs and the issue of whether the funding mechanism would do something are not the same. An issue which could arise for the comprehensive scheme, which arose in Scotland with free personal care, is what happens if the local authority were to seek to purchase for everybody, the people who are now privately funded as well as those who are publicly funded. My understanding of what happened in Scotland is that care home providers were very unhappy about that and that on the whole has not happened. Again, I suppose this could arise under any of the funding systems so maybe the two issues are not that closely related.
Sandra Gidley: So you do not think there will be a connection.

Q191 Dr Stoate: When we talk about people living on their own and having greater dependency needs in the future, someone always talks about the dependency ratio between the number of people economically active compared with those economically inactive and how we sort that out. Is that always the case? There are clearly younger people who are not economically active and older people who are. What is your view about whether that is a real issue or not?
Mr Wittenberg: The dependency ratio I have come across is often simply the population ratio of numbers of people over 65, over state pension age, and either the rest of the population or the rest of the working-age population. I think that people seem to find that, as far as I can tell, a very useful, very quick summary indicator of the changing balance between younger and older people. Clearly when one is looking at long-term care demand one has to go rather deeper than that and realise several things. One is that 40% of the gross expenditure on social
care actually relates to people below 65. Secondly, of the 60% that relates to people above 65, the vast majority actually relates to people above 75 and in many cases even older than that. I find the dependency ratio perhaps very useful as a headline starting figure but clearly in doing detailed work we need more detail. In addition it has been pointed out that there are plenty of people working beyond state pension age and there are plenty of people who have retired before it.

Q192 Dr Stoate: Obviously productivity tends to change over time, probably tends to increase in supply over time and so as we go along outwardly improves. Does this have implications for affordability, given that the country will presumably become wealthier over time?

Mr Wittenberg: Yes. When we presented our results from the model we have done we presented projected expenditure relative to gross domestic product, national income for that very reason. What complicates it, as we discussed earlier, is the real rise in unit costs. There is in a way a link between these things. The reason, for example, that the Treasury projects in the long run—I am not talking about now of course—rises in economic growth of GDP is partly issues of changes in the working-age population, in the workforce, and partly increases in the per person productivity and that in turn then feeds into issues about average earnings and unit costs. Absolutely clearly one would hope and expect that when we come out of the recession the economy would grow again and that would affect affordability, but one has to recognise that the same forces may cause the unit costs to rise. The two are interrelated.

Q193 Stephen Hesford: Models and projections and predictions and forecasts. Can you unpick what they are? What should we really be talking about? Models and projections and what are we doing? What do you like to talk about?

Mr Wittenberg: I personally like to talk about projections really because I feel that is what the PSSRU, along with colleagues at Leicester and the University of East Anglia and elsewhere, have been doing. By which I mean that we are not saying this is what will definitely happen because that, for reasons we have discussed, is impossible. We would rather say “On this set of assumptions this is what we think expenditure would be like. On that set of assumptions it will be something else. This is what I would understand by projections. It is on a set of assumptions and scenarios about some of the drivers of expenditure. I personally talk about projections.

Q194 Stephen Hesford: In an historical sense, I do not know how long you have been with the Department or the Civil Service, maybe some years—

Mr Wittenberg: Yes.

Q195 Stephen Hesford: You have seen a few projections and a few outcomes and the two may or may not be the same thing and they may be vastly different. How confident, based on your experience over time, have you become in your projections as against what you know then actually happened?

Mr Wittenberg: That is something we have sometimes been asked but never really pursued, to check whether the projections produced for the Royal Commission met with reality and we have not done this partly because we know that so many factors have changed that we did not know about at the time. It is doubtful that would be a useful exercise.

Q196 Stephen Hesford: From whose point of view? Your sanity?

Mr Wittenberg: No, from the point of view of commenting on whether the model is good or not. Because if a lot has changed—

Q197 Stephen Hesford: Sorry, but you said model now not projection.

Mr Wittenberg: Right. Maybe I should say the model is the piece of software, for micro-simulation it is a piece of computer code for the aggregate model is an Excel spreadsheet. What is sitting on the computer is the model and its output is the projection. I am sorry if I did not explain that earlier.

Q198 Stephen Hesford: You do your best and that is where we are.

Mr Wittenberg: Yes.

Q199 Stephen Hesford: You make the assumptions and then unforeseeable variables which you have just spoken about, changes in mortality, morbidity, fashion, risk factors, medical progress, migration, inward, outward, birth rate all these things. What is the margin? Do different variables have different margins of error so that some are more confident than others or are they all the same?

Mr Wittenberg: They are not all the same. It is something we have looked at quite a bit because it does depend how far ahead one makes the projections for; I should make that point. The projections we have produced, particularly to look ahead say 20 years or more, become particularly sensitive to assumptions about unit costs; the 2% we were talking about earlier versus 1% obviously compounds over a 20-year period and that becomes enormous. By contrast, we have looked at life expectancy, we have looked at the various official projections; ONS produce low and high life expectancy projections and by contrast the difference is considerable but it is not on that same scale. We did have a bit of dialogue with ONS about that and they said that was a function of what they felt were appropriate scenarios. Our colleague at LSE, for example, Professor Mike Murphy, has produced a yet higher life expectancy assumption and has explained at a recent seminar his reasons for that, but even that is not certain. The unit costs appear to be particularly important. Looking ahead a long period of time again the dependency rates, the work we have done with Carol Jagger, it is clearly very important that over a long period of time, if there is compression or expansion or morbidity, that
matters. Informal care? We have found that a bit less, if there were relatively small changes in the supply, but again it depends hugely on assumptions one makes about what would substitute for informal care. Similarly, if we get a change in rates between residential and home care that will not make a huge difference unless one believes that the home care package is going to be a lot cheaper or a lot more expensive. My feeling is that the biggest issues really are the unit costs and the disability dependency issues in terms of sensitivity and perhaps I should have said expectations as well which are of course almost unknowable.

Q200 Stephen Hesford: If you look at opinion polls, for example, and they have had problems over the years—they got the 1992 election wrong—they have a well-known and well-understood plus or minus margin of about 3% of their core projection. Do you have a plus or minus margin or some margin for your projections?

Mr Wittenberg: No, because the issue is really different. What is causing the opinion polls to have this plus or minus 3% relates simply to the fact you have taken a sample, typically 3,000 people instead of all 60 million of us in the UK. Modelling is something different. It is partly that we are using sample data, for example from the British Household Panel study, but it is mainly these other factors and therefore it is not at all comparable with opinion pollsters.

Q201 Stephen Hesford: Are you saying your modelling is bigger and better and therefore is not subject to this?

Mr Wittenberg: No; absolutely not. It is subject to more uncertainties. May I just make one or two other points as it may seem that I have been terribly pessimistic about the modelling? That is not the message I intend to convey. I intend to convey that there is a lot of uncertainty but surely it is far better to make big decisions with such evidence as one can get, recognising its uncertainty, I should like to make that point. May I also say that it may well be that when one is looking at different funding systems, things like the life expectancy, if one got that wrong, that would affect all of them? So the gap between the net extra cost will differ of course but it may not be that dramatically out as the totality will be.

Q202 Chairman: We are in this sphere of Rumsfeld’s known unknowns here. I am tempted to ask you whether you know how variable your unforeseeable variables are or is that another Rumsfeld question? The implication of what Stephen has been saying is: what have you learned by this type of modelling over the years, if you have been using big cohorts and unforeseeable variables? You have a measure of them over time presumably.

Mr Wittenberg: I can answer for some bits but not for others. As far as the GAD, now ONS, population projections are concerned, they did do their own analysis of the extent to which they had been out in their previous projections. My recollection of the paper I have seen, though it may not be the most recent, is that they found that the biggest problems related to the 85-plus group which is unfortunate because they are so critical for this purpose. I think they were 10% out over a decade but I may not have got the figures quite right. I would have to check. They have looked at it and they have produced information on their past errors that one can look at. At one point we did our modelling saying “Supposing they were out by the same amount in the future” but of course ONS would have learned from their past error rate and taken that into account so I am not sure it is right to do that; for that one there is information on past error rates. I do not know whether one can do the same on disabilities. For unit costs we can look at past information and try to see how much those have risen and they have turned into rises in real terms over certain periods of time and a bit less at others. Expectations? I do not know how one would do that.

Q203 Mr Scott: Informal carers make a key contribution to supporting people with long-term care needs. Can you explain the interaction between informal and formal services, who does what and for whom?

Mr Wittenberg: By “interaction” do you mean if there is more formal care, what happens to informal care and vice versa?

Q204 Mr Scott: Yes.

Mr Wittenberg: There is definite evidence for England that with home care, people living alone get more care than those who are married and living with a spouse. So the system is not carer blind; it appears that councils do take account of whether or not someone has a carer when they decide on care packages. We did not find that in community nursing which is different, so in that sense, from the point of view of the council, they do appear to take account of the amount of informal care. There is a whole body of literature about the relationship between formal services, councils in our case, and informal carers—whether they treat the carer as a co-worker or an additional user and so on. There is also literature the other way round, that is to say: supposing formal care increases, do the informal family carers drop out? The literature of which I am aware suggests no, they do not drop out. They may reduce the hours a bit but not hugely and they may change exactly what they do. For example, one piece of evidence I am aware of relatively recently is the situation in Scotland where Professor David Bell commented in his report that the expansion of home care linked to the free personal care in Scotland appears not to have caused family carers in Scotland to drop out of providing care.

Q205 Mr Scott: Would it be fair to say, with changing circumstances and the invaluable work that informal carers do, sometimes unsung heroes to be honest, that the pressures in a family of maybe both people having to have jobs now is going to impact and informal carers will not necessarily be
able to put that time in any more which will obviously increase the burden on informal care? Would you agree with that?

Mr Wittenberg: It is something that is much discussed as to how much employment impacts on care. I think the evidence I can recall—I cannot remember chapter and verse—is that it depends hugely on the number of hours of caring; a small number of hours of caring may not prevent people remaining in employment. The biggest circumstance where there appears to be a reduction, from what I can recall, is where the people are older workers and who are providing very large amounts of care. As far as I am aware, vast numbers of people are not dropping out of caring because of employment, but some are. It must be very difficult to know really what will happen in the future.

Q206 Sandra Gidley: Alexandra Norrish from the Department of Health told us last week that there are good grounds for treating differently older and younger service users, mainly because of the differences in their needs and differences in financial means. Have you done any modelling on the difference between the two? Are there any differences as far as you are concerned?

Mr Wittenberg: We have a model for younger adults which leads into the work we have done for the Green Paper as well as the modelling for older people. We have considered issues about the resources and clearly they do differ. For example, half the expenditure for young adults relates to education, and the numbers are rising very greatly. As I understand it, the evidence in work by Professor Eric Emerson of Lancaster, for example, suggests, as you would expect, that most people with learning disabilities have few savings and few sources of income other than social security benefits. That puts them in a different position from an older person who may well own their home, because home ownership among older people has been rising and the value of the homes—not recently but until recently—have been rising as well. The economic circumstances are very different and that has led us to look at the modelling differently. For older people there is an overwhelming case for separating the two because of market factors. There are also issues as to whether it is necessary to provide the same care package in order to achieve the same outcomes for older and younger people. There is a lot of scope for discussion around this.

Q207 Sandra Gidley: A slightly different question. Is there any evidence of age discrimination in social care services?

Mr Wittenberg: My colleague at the University of Kent, Professor Jules Forder, did a report for the Department of Health which was published in the summer of last year which looked at that question using data sets. It looked also at the British Household Panel Study and the evaluation of the individual budgets which I mentioned earlier. He found that there were differences in receipt of care, looking effectively at amounts in money terms per week between older and younger groups after standardising as best as possible for need. Whether that is discrimination is of course a second question. That depends on what one counts as discriminatory. I had better leave that.

Q208 Sandra Gidley: There is no overt and covert discrimination.

Mr Wittenberg: I agree that legislation has direct and indirect but what I am saying is that the modelling that Professor Jules Forder did looked at the differences; whether discriminatory or not is in a sense a second set of considerations.

Q209 Sandra Gidley: Were there any cost implications of addressing those differences that he highlighted? How significant was it?

Mr Wittenberg: The conclusion of the research that Jules Forder did was that, subject to a long list of caveats, the cost to public funds of eliminating age discrimination in adult social care by increasing the services for older people would be in the range of £2 to £3 billion per year but that was on the basis that all differences had to be eliminated. Whether that is the case or not is quite another matter. He commented, for example, and others have commented, that there may be differences in the unit costs and you could have an identical care package for a younger and older person but the cost is different because of market factors. There are also issues as to whether it is necessary to provide the same care package in order to achieve the same outcomes for older and younger people. There is a lot of scope for discussion around this.

Q210 Sandra Gidley: I am a little confused. How can the same care package cost less to deliver to somebody who is older?

Mr Wittenberg: I was thinking in particular of care homes; it could do if the competition is far greater among the providers. That may be true for some very specialist groups of younger users. If there are not many providers there is scope for a bigger mark-up and there is a suggestion that may be happening. That is just an example of why one needs to take the £2 to £3 billion with caution.

Q211 Sandra Gidley: When you say “a bigger mark-up” it could be him saying that we are being ripped off for younger adult services.

Mr Wittenberg: I am not aware of particular evidence.

Q212 Sandra Gidley: There is no evidence either way.

Mr Wittenberg: I am not aware of evidence one way or the other but it has been suggested that the mark-ups could differ and that it could be part of the explanation of the expenditure differences.

Q213 Dr Naysmith: One idea which is incorporated in the Green Paper is building the budget for Attendance Allowance into social care funding and
that is proving quite controversial. I know it is controversial because a lot of people in my constituency have written to me about it and yesterday there was a lobby here of people with disabilities and this was one of the points they were raising. Could you tell us about the main characteristics of this benefit and how it relates to the social care system?

Mr Wittenberg: The main characteristic is that it is a benefit payable at two rates: a lower rate and a higher rate. Unlike social care, it is not means-tested and I think I am right in saying that it is also not taxable. The numbers of people receiving Attendance Allowance is around 1.3 million in England recently. It is therefore rather larger than the numbers we were talking about earlier; the numbers of people receiving home-based community service. A wider group of people apparently seeking Attendance Allowance and also some receiving Disability Living Allowance need to be thought about as well. I have a note about the overlap between the two which might be useful. An analysis that colleagues did of the data set known as ELSA for the Wanless Review, for example, found that only 26% of the Attendance Allowance group received social care, either publicly or privately funded, and that 29% of the Attendance Allowance people received neither formal nor informal care. So the overlap is not overwhelming between the Attendance Allowance and social care. It is to a considerable extent a bigger, wider group of people and to some extent a different group of people in the community receiving Attendance Allowance. As far as care homes are concerned, as you know, the publicly funded group in care homes are ineligible to receive Attendance Allowance after the first four weeks.

Q214 Dr Naysmith: Do you think it is reasonable to include in the Green Paper as something to be considered in this way?

Mr Wittenberg: I feel that is a policy matter.

Dr Naysmith: Last week one of our witnesses painted a picture of rich pensioners using Attendance Allowance to pay for the odd luxury item like SAGA cruises. Do you think there is any validity in this criticism?

Q215 Chairman: Is there any evidence?

Mr Wittenberg: As I understand it, colleagues tell me this was a comment made at one of the consultation events; someone said they had heard this. My understanding is that some of the stakeholder groups are quite interested to find out how people actually spend their attendance allowance and have told colleagues at the Department that they hope to include that in their responses to the consultation. I have to say that I think it is methodologically quite difficult. If you ask people what they spend their Attendance Allowance on as opposed to their pension, I am not sure how easy people would find it to answer that.

Q216 Dr Naysmith: You are not going to find out really.

Mr Wittenberg: It would be difficult to get a categorical answer to this question.

Q217 Dr Taylor: I was grateful to you for explaining your idea of projections, predictions and modelling because I was quite confused. We were given an indication by the Department of Health that your Unit is doing some modelling relating to the funding options. Could you let us know how far advanced the actual quantitative analyses of the funding models in the Green Paper and of the free personal care policy area are? When can we expect these to come to light?

Mr Wittenberg: May I start with the Green Paper first? The Department of Health has commissioned a whole programme of modelling from the Personal Social Services Research Unit over an extended period and originally goes back to the time of the Royal Commission. One block of modelling has been published in the sense that the PSSRU published a discussion paper, DP2644 actually, which describes the micro-simulation model and it also presents some outputs from the model on the current funding system. When I think about it, papers were published earlier, in March of last year, which looked at aggregate projections for old and younger people. In addition, the outcome of the modelling at an aggregate level that PSSRU have done for the Department appears in the impact assessments for the Green Paper which of course are on the Department of Health’s website. All of this is actually available. The Department is continuing to commission further modelling from the PSSRU and that is in progress. I understand from colleagues the Department’s plan is in 2010, next year, to publish another block of output from modelling.

Q218 Dr Taylor: Twenty ten is rather wide. Can you give us any more accurate timing? The consultation on this thing closes on 13 November so we are not going really to have any idea of the different costs of partnership insurance, comprehensive, before we respond to the consultation.

Mr Wittenberg: There are figures in the impact assessment on the costs that have been published. If people want to look at the details, the impact assessment for that purpose is useful reading alongside the Green Paper. You asked me when in 2010. I am really sorry I do not know. I will go back and ask colleagues or you may wish to ask the Secretary of State when you interview him.

Dr Taylor: That would be the way forward.

Q219 Chairman: Do you think that key features of future funding systems such as its universality depend on some of the factors which have been mentioned this morning, for instance unit costs or how unit costs will grow or the availability of informal care? Are those and other aspects going to determine the future?

Mr Wittenberg: They will clearly have a huge impact on the expenditure but when it comes to choosing between options, clearly there are value judgments
involved. As I see it, the projections are a tool, they give information to decision makers but then in choosing between the various options on which the Green Paper is consulting, clearly there are value judgments and modelling alone is not going to answer questions. What it is going to do is give one indications of probable balance of costs really and then decision makers need to think about issues of cost effectiveness and in particular issues of equity and whatever other values they feel it appropriate to assess the options against.

Q220 Chairman: Professor Jagger, I realise you have been sitting there for quite a long time now. I am going to give you the opportunity; it is entirely a matter for you whether you want to take it or not. Do you have anything further to say to the Committee?
Professor Jagger: The only bit of information that I have not made clear, when we were talking about the impact of key diseases on disability was that by the time people reach 85 and over it is not a matter of a key disease that they have; they have a number of diseases and there is a high degree of co-morbidity. It is not as easy to disentangle what effect a single disease might have in that population.

Q221 Dr Naysmith: May I just tease out something else? You were talking about people who were overweight or obese being a little bit protected. I am pretty sure what you were trying to say, although I was not very clear, was that people were not protected by their obesity; they were protected because they went for extra tests and were picked up by the system. Is that what you were trying to say? Professor Jagger: Yes, although a common condition in the very old is falls.

Q222 Dr Naysmith: If you do not move, you do not fall much.
Professor Jagger: If you have a little more cushioning you are less likely to get your hip fractured.

Q223 Dr Naysmith: It is a complex area.
Professor Jagger: It is a complex area.
Chairman: No further questions. May I thank you both very much indeed for coming along? It has been a very interesting session.
Q228 Chairman: So the unmet need will always be unknown basically if you do not measure it all.

Mr Humphries: Absolutely. If we look at the demographics of the population in terms of the income and wealth profile of people who need care and support, we know that more and more are falling outside that public funding criteria and are therefore, in the words of one report on the subject, lost to the system. They do not appear anywhere on the radar of need.

Q229 Chairman: You mentioned the dependency on informal care; normally family members but it can be others as well. How much does the system depend on informal care really? Is it too much or do you think current levels are sustainable? Is the pattern shifting in informal care?

Mr Humphries: First of all I think you would find wide consensus if not unanimous agreement that the system does rely heavily on informal care. You only have to look at the fact that we have one and a half million people in the paid social workforce and probably at least four times that number providing unpaid informal care. To give you an idea of the scale of the extent to which without that informal care services would be in real trouble, in many cases—and carers’ organisations could give you chapter and verse on this—expectations are too heavy, too unrealistic and that leads to breakdowns in care arrangements which could be avoided. Actually it would be much better from a preventative point of view to provide good support to carers in the first place because that is the most cost-effective and appropriate way of meeting their needs.

Mr Lloyd: Carers UK published some research from the University of Leeds which estimated in 2006 or 2007 that the equivalent cost of total informal care provision across the whole of society was around £87 billion per year.

Q230 Chairman: I find this quite interesting. If you look at our social care network, which really comes out of what we call the welfare state, of course 150 years ago this did not exist. We had family units which cared for people, did not think there was any obligation on the state or that anybody else should or indeed that they could be rewarded for looking after a member of the family. Do you think we are posing and measuring the right things here? Is it not the case that you have responsibilities as a parent or maybe as a son to an elderly parent to look after them or look after young children. How do we get the measure of what informal care means and what it should mean? I know it is possibly an ethical or potentially moral judgment but what is your view on it?

Mr Humphries: We are having to find new answers to that question because the nature and structure of families have changed.

Mr Humphries: We no longer have big extended families. Instead we have these very long vertical families where you have great grandparents, grandparents, parents, their children and their children’s children. You have what some people call sandwich carers who are actually caring for their ageing parents and helping their own children look after their children with childcare as well. The whole nature of the caring task has become more complex in a fast changing society. That is one of the pressures that reform of the system has to address.

Q232 Chairman: Is it easy to measure what informal care is then?

Mr Humphries: I hesitate to comment authoritatively on that because the carers’ organisations would be much better placed to give you an answer to that.

Mr Lloyd: The question I suppose is to what extent is it appropriate or ethical as a society to rely on the excessive provision of informal care in which, for example, somebody might be providing pretty much close to 24/7 care. Certainly there is hard quantitative evidence that excessive informal care provision does impact negatively on people’s outcomes, whether in terms of quality of life or health. There are obviously numerous mediating factors: hours of care provided per week, household income, access to transport, social support networks and indeed the characteristics of the person who is receiving care. I did some research a couple of years ago with the National Centre for Social Research and we analysed some social survey data, hard, quantitative, rigorous data and it did find that individuals who provided more than 20 hours of care per week particularly to a partner—this is in the older population—did show a statistically significant lower quality of life than equivalent non carers. I would emphasise that this was not really just a sort of woolly question asking about their quality of life. This was using a scientifically developed set of measures incorporating 19 questions to provide a very detailed, accurate, scientific measure of quality of life. I would also say another interesting aspect of that research was that the outcomes of the carer were particularly related to the memory functioning of the person receiving care. In short, if somebody has Alzheimer’s in various stages the effect on the informal carer will be that much worse than other types of condition.

Q233 Dr Stoate: I should like to look at some of the options in the Green Paper and see where we go from there. The Department of Health told us last week that the voluntary co-payment options in the Green Paper were based largely on the work by Derek Wanless which of course he did for The King’s Fund but they also said there were some important differences. Can you help us with those differences?

Mr Humphries: Yes; certainly. The Green Paper does echo the main principles of the partnership model which was put forward in The King’s Fund review carried out by Sir Derek Wanless. The central idea is that funding of care should be a shared responsibility between the individual and the state. That was what the Wanless review said and that is what the Green Paper has echoed in its partnership model. There are some differences however. The first one is that in The King’s Fund proposal the proposal was that 66% of
the cost of the care would be met by the state. The Green Paper is putting that proportion lower; putting it between one quarter and one third. The other very significant difference is that in the original King’s Fund proposal, on top of that 66% there was a proposal that for every pound the individual contributed on top of that towards the cost of their care the state would match fund. That aspect is not present in the Green Paper version of the partnership option. We think that is an important component of the original partnership.

Q234 Dr Stoate: I was just going to ask you whether you thought that mattered and you think it does.

Mr Humphries: Yes. Certainly the review team which carried out that review thought it mattered and I am inclined to agree with that. One of the sources of unhappiness about the current system is that it penalises people who make provision for themselves and it does not actually encourage or incentivise people to contribute towards the cost of their care.

Q235 Dr Stoate: And you think the Derek Wanless model does?

Mr Humphries: Yes.

Q236 Dr Stoate: So what you are saying is that the Derek Wanless model would actually encourage more people effectively to make arrangements for themselves.

Mr Humphries: It would and that gave it a significant advantage; not an overwhelming advantage but a significant advantage when compared with other ways of paying for care.

Q237 Dr Stoate: That is interesting. Some people say that the co-payment model is flawed because anyone with high needs and high assets could still end up with an uncapped bill. Is that a good situation or a situation that you recognise?

Mr Humphries: It is the only way. Yes, I think that is the case but the only way you can avoid an uncapped bill is by putting a cap on it and that means either a voluntary or a compulsory insurance arrangement. I do not see any way round that for people with very large assets.

Q238 Dr Stoate: Presumably people with completely uncapped possible liabilities are not going to be very happy with effectively funding other people’s care. Surely the incentive for them would just be to opt out because they face unlimited care costs anyway.

Mr Humphries: Yes and that is one of the tradeoffs which the funding reform option has to address.

Q239 Dr Stoate: One of the advantages of the Green Paper effectively is that those with higher means and lower need will effectively fund those with lower means and higher need and that would go counter to that view.

Mr Humphries: Yes.

Q240 Dr Stoate: Is it also right to say that the care packages in the Wanless review were much more substantial than current packages?

Mr Humphries: They were more generous. They were modelled around a view about a particular level of need which you can adjust within the statistical model that was used. Yes, another significant advantage of that model was that it did something about the problem of unmet need which currently the Green Paper options do not address directly and that is a significant area for development in those proposals.

Q241 Dr Stoate: Would you go as far as to say then that the Government should simply accept Wanless and get on with it?

Mr Humphries: It is not quite as simple as that. Things have changed since the Wanless review was carried out. We need to bear in mind also that it was a review about the funding needs of care services for older people. We have become much more aware over the last three years of the need to address the funding needs of working-age people with care and support needs and Wanless really did not address that; he was not asked to. The second and most profound change was that the economic situation has changed dramatically. The partnership model in the Wanless review was always more expensive than the current means-tested model and other models that were looked at and not as expensive as free personal care. We now have to ask question about sustainability in the long run about applying that model, which is why we are recalculating all of those figures so that we have an up-to-date view about what that Wanless model would actually cost now alongside some of the other options. We can certainly let the Committee have that information as soon as we get it.

Dr Stoate: We would certainly like to see that.

Q242 Dr Naysmith: Mr Lloyd, can you talk about the report that you wrote in 2008, the one for the International Longevity Centre-UK? I understand that it proposed that long-term care should be entirely funded from a state insurance scheme with “auto-enrolment” incorporated and that means that everybody is automatically signed up, but individuals can opt out if they want to. Why do you think that your idea was not in the Green Paper?

Mr Lloyd: Some elements of it were. The idea of creating a state-sponsored insurance scheme into which people in retirement would make contributions through flexible mechanisms is in the Green Paper in both the voluntary model and the comprehensive model. What did not make it through into the Green Paper was the principle of “auto-enrolment”. When I wrote my paper 18 months ago I took the view that a mandatory approach to contributions would be politically unfeasible. I thought that a purely voluntary approach to contributions would result in very low levels of participation so “auto-enrolment” is the middle way. It is the compromise solution which is
also being rolled out in pension reform and personal accounts, as you may know. The critical point here is that there are perhaps two types of “auto-enrolment”. It is my understanding that the Department of Health did look at what could be called hard “auto-enrolment” which is the idea that somebody does nothing but is automatically enrolled into a scheme. I understand the Department of Health rejected that on the basis of legal advice that it would breach European law around the selling of financial products. Whether or not that advice was accurate and whether or not the Commission would take action against the UK for pursuing this “auto-enrolment” in relation to a state insurance scheme I do not know, but that is hard “auto-enrolment”. What I am still keen to explore and keen to ensure the debate focuses on is the idea of soft “auto-enrolment” which is the idea of mandated choice so that you cannot just ignore the issue of choosing to insure yourself; you have to make a choice. You can dream up and conceive of various mechanisms in order to achieve mandated choice. The best idea I have heard so far is that when people come to receive the state pension, at that point they would have to fill out a form, perhaps confirming where they live and they would be required to fill out this form in order to claim state pension but on that form you could also have questions about participation in a state sponsored insurance scheme. I do think that there is still some merit in exploring the idea of at least soft “auto-enrolment” to ensure high levels of participation in what is ultimately still a voluntary insurance scheme.

Q243 Dr Naysmith: It seems to me that it would be a very good idea to force people to face the issue at a time when they had the chance to face it. It would also mean that there would be some people who would sign up and say yes and go for the “auto-enrolment” who would then find they could not pay the premiums. What would happen to them?

Mr Lloyd: The approach I have always taken is that the responsibility of the Government here, given the absence of new state funding, is to make it as easy as possible for individuals to use the wealth that they have to insure themselves against the various risks involved in long-term care. That would probably involve people having the option of making a lump-sum contribution at 65, making regular contributions out of income or in fact deferring the premium until after death. There are various administrative challenges in all of these and implementing them but that was my guiding principle: if people have the wealth and if the Government and state cannot afford, because of fiscal considerations, to increase public spending on social care, the job of the state and the Government is to make it as easy as possible for people to use their wealth, including, critically, their housing wealth.

Q244 Dr Naysmith: Are you suggesting that schemes like this have been thought of elsewhere? I know yours is original but is it happening anywhere else in the world? Did I hear you mention Canada just now?

Mr Lloyd: Canada no. The country to which I would draw the Committee’s attention would probably be Singapore where they have a variant of a state-sponsored insurance scheme called ElderShield. The ultimate objective of that scheme, as it happens, is for people to make working-age contributions from the age of 40 into long-term care insurance but recognising that, following the implementation of the fund, you would still have a transitional older generation who had not made any contribution, there was an arrangement there for people in retirement in Singapore to make contributions into the insurance. I would need to check but I believe that was on the basis of a lump sum or monthly contributions.

Q245 Dr Naysmith: Is not any insurance scheme without compulsion doomed to fail because not enough people will take out insurance and those who do will be those with the highest risk. It is sometimes called the problem of adverse selection I believe.

Mr Lloyd: There are two points there: there is adverse selection and levels of participation. It is in my understanding, certainly from private insurance companies, that adverse selection is not a problem in relation to long-term care insurance because adverse selection only occurs if you can accurately predict your ultimate accumulated care costs. Whenever people mention this to me I always turn the question round to them and say: are you going to need care? How long will it be for and what will be your accumulated total care costs? If you cannot answer that then you have effectively answered your own question. In terms of levels of participation, that goes back to my other point that introducing now a mandatory contribution system would be politically unfeasible. Equally, if it were purely voluntary, that would risk low levels of take-up. The way I approach this is that it is not really a kind of either or choice, which is a little bit how it is presented in the Green Paper. It is actually better to think of it as a phased approach so that you might start off with voluntary contributions and go through the administrative process of setting up a state-sponsored insurance scheme. Subsequently, when that is all up and running, you could then think about some mandated choice. People are becoming far more aware of the need to pay into an insurance scheme and it may be that at a later stage after that, when economic and fiscal conditions were appropriate, you could think about mandatory contributions from people in retirement. If you were going to do that, you might also want to think about mandatory contributions into a state sponsored insurance scheme for long-term care for people of working age as well so that people of my age, if you like, were also making contributions into a long-term care insurance scheme. Then after 30 or 40 years you are left with a fully funded long-term care insurance system.

Q246 Charlotte Atkins: We heard from the Department of Health last week that their three shortlisted options were basically what they called “progressive universalism”, which means, as I
understand it, part universal, part targeted. In your view is that just a fudge that will not actually satisfy anybody?

**Mr Humphries:** I suspect the devil is in the detail on that. As I understand it, what the authors of “progressive universalism” are trying to get at is the idea that everybody gets something. Unlike the current system where if you have £23,000 you get nothing and you are on your own, in a more universal system everybody gets something. What you get beyond that is calibrated according to your means and circumstances. We can all sign up to that as a good thing in principle, but the question is: what particular policy levers do you use to make that work and how do you line up the resources behind it? It seems to me, focusing on older people for a moment, we have a very incoherent approach across how we apply resources to the needs of older people. We have about £16 billion of public money for social care which is incredibly targeted and rationed through that safety net kind of approach. We have some large chunks of money through the benefits system—Attendance Allowance springs to mind—probably getting on for about £4 billion, which is not very well targeted. Then we probably have another £3.5 billion on things like free TV licences, public transport, winter fuel allowances which are not targeted at all and are completely universal. That does not seem to be much coherence in terms of the thinking behind some of those things being universal and other things being targeted. We have to be clear about what it is we are trying to achieve. It is not just about the money either. One of the big problems in the current system is that self-funders are left to their own devices and part of the universal entitlement—and this is where the Green Paper is helpful—is that everybody, however much money they have or do not have should be entitled to good information and advice and everybody should be entitled to an assessment. That would be a massive step forward. Trying to put some flesh on the bones of what universalism means would be a good starting point.

**Q248 Charlotte Atkins:** You mentioned the Attendance Allowance which you said was not well targeted. Would you say that it does meet some of the unmet needs at the moment and therefore is valuable? Or do you think that something like the Attendance Allowance basically has to be rethought?

**Mr Humphries:** Clearly many people value the Attendance Allowance enormously and for many people it does meet real needs. We have a problem that we do not know anywhere near as much as we need to know about who gets it, what they do with it, their own income and wealth position. We do know that some people use it towards care costs which should be met through the care funding system. One of the characteristics of the system we have in England is this kind of mish-mash of benefits and care services and the two are quite confused actually compared with what we see in other countries. We cannot really be clear that the Attendance Allowance, that large lump of money, is achieving what it could achieve if it were part of a proper coherent package of support for care funding.

**Q249 Charlotte Atkins:** Some commentators have suggested that, if you take account of the loss of Attendance Allowance and the cost of board and lodging in care homes, the comprehensive option is little cheaper than going for the annuity insurance approach. Would that be a better way of capping the costs in terms of older people who actually need care as opposed to choosing to go down that option?

**Mr Humphries:** It is very difficult to make an economic evaluation of the Green Paper options in those terms because we do not have enough modelling information to help us understand what the true costs are so that is quite a difficult judgment to make.

**Q250 Charlotte Atkins:** Mr Lloyd, do you have any perspective on this?

**Mr Lloyd:** Yes. As Richard says, “progressive universalism” is that everybody gets something but what you receive is proportional to your income and wealth. Effectively it is a polite term for means-testing. The partnership model in the Green Paper is a progressive universal system with reallocation of Attendance Allowance through a new social care system and it seems to me that makes sense and the controversy which has been caused by that reallocation, which is ultimately just administrative, not a change in funding, is unfortunate but you then go back to the problems of means-testing old people in retirement. People resist it, people resent it, people game the means test and it could be said to penalise people who have saved for retirement. That is a slightly moot point because most of the wealth people have in retirement when they annuitise their pension wealth is actually their home and it is not clear whether people earn the wealth in their home or they just accumulate it. Fundamentally it does to an extent penalise people who have saved for

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2 Note by witness: Game is the term used to describe someone deceiving a means-test, e.g. falsely stating level of income.
retirement and also, critically, it does disincentivise people to save for retirement like any form of means-tested retirement benefit from the state, like pension credit, housing benefit; it disincentivises people to save for retirement. I think that “progressive universalism”, means-testing, is going to be an inevitable feature of the social care system at least for the next 10 to 20 years but if we have in the long term got in mind a system of working-age contributions for long-term care insurance, then there is no reason over the long term we can get rid of means-testing or progressive universalism altogether.

**Q251 Charlotte Atkins:** So your “auto-enrolment” idea really.

**Mr Lloyd:** The “auto-enrolment” idea responds to the problem of the older generation now and particularly the baby boomers, this very, very wealthy cohort which is retiring right now. If you were starting from scratch and you were looking to the very long term, then you would be looking at working-age contributions from people in their thirties and forties.

**Q252 Dr Stoate:** I should just like to pick up a point about the Department of Health last week who pretty much ruled out a tax-funded universal system comparable with the NHS on the grounds that it would place a heavy burden on people of working age. Do you think that is a reasonable reason for not even considering it?

**Mr Lloyd:** You first of all have to take a step back and recognise that we do have an ageing population, we do have a declining elderly support ratio, so simply to maintain spending on the NHS and the state pension at equivalent levels today will mean that the tax burden will have to increase, so it will mean that income taxes will have to increase regardless of what we do to social care. People particularly who are now in their twenties and thirties will necessarily have to face higher income tax over their lives, if we are just to maintain spending on the NHS and state pension.

**Q253 Dr Stoate:** Is that necessarily a bad thing? Given that it has to be paid for somehow, is it a bad thing just to say “Income tax should cover it. Income tax may have to rise”? Is that necessarily a bad thing?

**Mr Lloyd:** There is a whole set of competing policy objectives here. NHS spending is already constrained and I am sure members of the Committee know problems around that. Spending on the state pension is also problematic because of the existence of pension credit. The state has officially recognised that the state pension is insufficient to live on. There is a case for fixing those and actually providing the entitlements that people thought they were paying into through their working life, that is a decent state pension and a NHS they can rely on. The pressure on that in the decades coming forward will be intense, given the larger number of older people claiming state pension and utilising resources of the NHS, given a smaller working-age population. To do that and then also to say that we will put up taxes for that and we will also put up taxes to pay for a universal system of free care would risk breaking the bridge between the generations in a sense. Certainly for the baby-boomers, for example, who have paid into a safety net system and not paid into a universal free care system, it is questionable whether they should be entitled to a universal free care system when they reach retirement. You have to look at sustainability arising from extending longevity, declining elderly support ratio and the fiscal situation we are obviously now in, but there is also a redistributive issue, there is a kind of pernicious redistribution that would be created if you were to put up taxes for this reason on people in their twenties and thirties to transfer wealth to people now who have sufficient wealth to insure themselves for long-term care. I always think of a 25-year-old graduate who is burdened down with tuition fees, who will never have the chance to save into a defined-benefit pension scheme, will only be able to save into a defined contribution scheme, so will have to hold their own investment risk for their retirement income and of course can only conceivably get on the property ladder sometime in their late thirties. The idea that you would put up taxes for them in order to provide free care for a cohort which has in particular very considerable property wealth feels to me slightly unfair and quite a pernicious redistribution.

**Q254 Dr Stoate:** That is fine and a very clear answer. Is there a possibility though that we are just simply overstating this. You are worried about pensions and you are right about the NHS, but is it possible that you are overstating the pessimistic assumptions on the burden of long-term care, given that just because people are getting older, does not necessarily make them more dependent? Why are we taking this view that it is necessarily going to be so much more expensive?

**Mr Lloyd:** If you were to increase state entitlement to something close to free personal care, so that all personal care and all residential care were free, the costs would be in the tens of billions of pounds. It would be incredibly expensive. It may be that if the Committee wanted to look at a tax-funded solution rather than a state-sponsored insurance scheme and a risk-pooling mechanism, that way, then you could always look at inheritance tax.

**Q255 Dr Stoate:** A fair point.

**Mr Humphries:** I agree with much of what James says. I would point out however that around one third of older people have no housing wealth at all. We have the inequalities in old age and we have to be careful that we do not try to develop a perfect funding system for an imperfect world. That is one caveat I would throw in. Secondly, I think the Green Paper and others have made a cogent case why tax funded social care is not sustainable in the long run. What I have yet to consider and why that argument does not apply to the even bigger sums of money spent on other aspects of services like the Health Service, pensions and all the other things. Why are we not having a big debate and inquiries into that as
going to be paying income tax as well, are they not?

Mr Lloyd: The income tax thresholds are higher for people in retirement obviously but if you look across somebody’s life course, the bulk of their payments through income tax are when they are of working age and not in retirement. If you were to put up income tax for people in retirement, that is the same as asking people to make contributions into a state-sponsored insurance scheme.

Q256 Dr Stoate: I was going to ask you about that and whether in fact the Green Paper addresses the needs of younger disabled people.

Mr Humphries: It does but in a roundabout kind of way and it reaches the default option that it would continue to be paid for out of the general taxation, either because they have not built up savings and wealth to be protected from means-testing or because they would not be able to opt for voluntary insurance anyway because the risk has already arisen. It does do it, but it is in a roundabout kind of way and a number of organisations have asked whether it could be more explicit about that position. One of the arguments of the free personal care option for everybody is that you get a single system as opposed to an insurance-based system for older people and a taxation-based system for working-age people. Some of the lessons from other countries suggest that a more unified approach is a better one. Ultimately it does come down to political choices about what you want to do with public money.

Mr Lloyd: May I clarify a couple of points? The rate of home ownership among people over 65 does vary by quite narrow age groups. Among people below 70 the rate of home ownership is considerably higher than among people over 70. It is, if you like, the right-to-buy generation. For the baby-boomers in particular, the rate of home ownership is over 80% and for those people who do not own their own homes, those are the people who will always be entitled to free care as now under the current existing system. In terms of the one system/two system approach, in terms of working age and retirement age, in the long term you can definitely work towards a single system which will be funded through working-age contributions. It is the route you take to get there and the compromises and political choices you take to get there. It may be that you have to have a transitional arrangement for 10 to 20 years where you have effectively two systems with older people making their contributions and at some point in the future younger people making their contributions. That will obviously just be a transitional system and over time you will be left with one single system.

Q257 Chairman: You mentioned that 80% of the baby-boomer generation are householders. Do we know what percentage of baby-boomer retirees are paying income tax at the moment? I am trying to get my head round this phrase which is used constantly in this debate about a heavy burden on people of working age. Of course baby-boomer retirees are going to be paying income tax as well, are they not?

Mr Lloyd: The income tax thresholds are higher for people in retirement obviously but if you look across somebody’s life course, the bulk of their payments through income tax are when they are of working age and not in retirement. If you were to put up income tax for people in retirement, that is the same as asking people to make contributions into a state-sponsored insurance scheme.

Q258 Chairman: Did anybody ever do a study of what was happening in 1948 when they introduced the universal National Health Service?

Mr Lloyd: At that stage the ratio of working-age people to people in retirement was so high that they did not particularly think of these issues. In 1948 nobody anticipated the baby-boomer generation; nobody anticipated what would have happened to longevity. Over that time trends in longevity have consistently surprised the projections of people like the witnesses you spoke to earlier.

Q259 Dr Stoate: You have just undermined your own argument in a way. You are telling me that people in retirement now do not actually pay that much tax because they live that much longer. A civil servant retiring at 60 on a decent pension would be paying income tax for probably 25 years which is not that much different from his working career. This idea that just because somebody has reached retirement age their contributions are no longer very big and no longer go on very long, simply is not true any more.

Mr Lloyd: That is an interesting point but you would have to get an economist to look at it precisely.

Q260 Chairman: If I had stayed working in industry and retired, as opposed to coming in here, I would be paying less tax on my pension than I will be after leaving here. Has anybody studied baby-boomer retirees’ taxation at all?

Mr Lloyd: We are getting into the private sector/public sector pension debate. Most people in retirement are asset rich and slightly more income poor. There is a huge variation in retirement incomes and I definitely take your point that people do pay income tax in retirement but I would go back to the point that I made that people over their life course will pay the bulk of their contributions through income tax when they are of working age.

Q261 Dr Taylor: Can we look at Scotland? I think James said that free personal care for England would put the cost up by tens of billions. How are they affording it in Scotland? What are the losses? What lessons can we learn from Scotland?

Mr Lloyd: The short answer is that Scotland does not have a system of free personal care. It has a much more generous system of contributions towards personal care costs, but the majority of people are still making out-of-pocket contributions to personal care and residential care.
Q262 Dr Taylor: They are paying hotel costs.
Mr Lloyd: They are paying hotel costs.

Q263 Dr Taylor: What contribution are they making to personal care?
Mr Lloyd: The levels of entitlement are in 2004 figures; this was research by Bell and Bowes. The cost of an average care home place in Scotland was £427 per week. After the £210 per week contribution from the state self-funders were therefore still paying an average of £217 per week.

Q264 Dr Taylor: So really it is a bit of a myth that it is totally free.
Mr Lloyd: Oh, yes.

Q265 Dr Taylor: Can we learn lessons from what they have done up there? Correct me if I am wrong, but one of the huge problems we heard about when we did the continuing care inquiry some years ago was that carers could be doing exactly the same job as nurses and if a nurse was doing it then everything was free, whereas if the carer was doing it, it was not. Have Scotland not eliminated that sort of problem?
Mr Lloyd: Following the Royal Commission, nursing care across the UK became state funded. Scotland made the step of introducing universal non-means-tested entitlement.

Q266 Dr Taylor: But the definition of nursing care seems to be the care given by a nurse, not what the care actually is. That was absolutely clear from people sitting at that table in the previous inquiry.
Mr Lloyd: I am not an expert on the Scottish system. I do not know how they distinguish between nursing care and personal care. It is a very precise definition. As you said, the rule of thumb is that nursing care is clinical care provided by a nurse or other medical professional. Personal care is care with the personal activities of daily living. The critical feature is that yes, in Scotland they have not given people blank cheques and said that any personal care that you consume will be entirely paid for by the state. All they have done is increase the level of entitlement and done that on a non-means-tested basis.

Mr Humphries: One of the big lessons of the Scottish experience for me is that whatever funding mechanism you adopt, it does not fudge the fundamental question of how much you need to spend on good social care. The Scottish experience has been that they have run out of money and therefore care has had to be rationed either through waiting or through eligibility criteria. The other thing they have done in Scotland is highlight variations from one local authority to another in how they have applied the definitions and the assessment and so on. A third lesson is about Attendance Allowance. When they introduced free personal care in Scotland my understanding is that you could no longer get Attendance Allowance if you were in residential care and receiving free personal care. This is the crunch: instead of that Attendance Allowance money going into the care budget it was retained by DWP as a saving against their budget and that explains some of the shortfall in the care funding in Scotland.

Q267 Dr Taylor: So there have been very real disadvantages of the system up there.
Mr Humphries: It depends how you configure it. The learning point about Attendance Allowance is that whatever Government does about Attendance Allowance that money does need to be ring-fenced in their system and not disappear as some kind of saving into another Whitehall budget.

Q268 Dr Naysmith: Have Scotland introduced the universal assessment that everyone is entitled to it no matter what?
Mr Humphries: I am not sure that they have. There is a national assessment but there is a problem about authorities interpreting it differently.

Q269 Dr Naysmith: That would be essential.
Mr Humphries: It would. They certainly have not gone as far as the Green Paper proposal here that there should be a national definition of assessment and eligibility.

Q270 Sandra Gidley: I just want to clarify something James Lloyd said. You read out the figures of what people were contributing personally but I think you have missed the point. Is personal care in Scotland just the personal care needs and hotel needs are picked up by the individual? You were not actually quoting personal care costs that were being picked up by the individual; you were quoting hotel costs that were being picked up by the individual. It is important to clarify that. Is that the case?
Mr Lloyd: Yes. I am going to say yes, but I am not an expert on the Scottish system, so I would refer you to somebody who is and who has done studies of it. It is important to be clear that it is an entitlement to a fixed level of entitlement that still leaves an awful lot of people paying out of pocket whether that is for domiciliary care or care in a residential care home.

Q271 Sandra Gidley: But it is quite clear that they do not pick up the hotel costs which at the moment are picked up.
Mr Lloyd: Yes.
Mr Hirsch: That is correct.

Q272 Chairman: We have been joined by our third witness now. Welcome. May I just ask you to give us your name and the position you hold for the record?
Mr Hirsch: I apologise; I was unavoidably delayed. My name is Donald Hirsch. I am an independent consultant on social policy. I have done a lot of work for the Joseph Rowntree Foundation on this subject and written several reports for them.

Chairman: Welcome. We have a specific question for you about your work with the Joseph Rowntree Foundation.

Q273 Sandra Gidley: In 2006 you wrote a report for the Joseph Rowntree Foundation and that suggested a partnership model with a state
contribution of 80% to the cost of care. How do you go about determining what the level of state contribution should be in a partnership model? Obviously Wanless came up with a different figure and the Green Paper is yet again.

**Mr Hirsch:** We have to be very clear about these different bases. Our calculation there was actually a particular illustration. What it showed was that if you took everything which was being spent on care home fees and registered domiciliary care, by public agencies and private individuals, put all of that together, actually about two thirds of that was already public but the remaining third was unaffordable to many people. If you wanted to create a system without any means-testing and a co-payment that everybody could afford, we reckoned that 20% was something that even with an averaged cost for a nursing home and somebody who was on pension credit, not the absolute maximum cost but something at the high cost end, somebody on a minimum entitlement could still afford to pay 20%. The point we were making there was that, if you wanted something which was really doing away with means-testing and it was a universal entitlement but to have a co-payment and roundabout where it could do while you were fixing the present system in the long term. They were not meant to be permanent solutions. It tried to identify some areas where people were really in difficulties which could be addressed and areas where people felt a sense of injustice which could be addressed in that way. One was increasing the personal expenses allowance for people who were in care homes and that was just a matter of dignity that we thought roughly £20 a week was just not compatible with dignity and it would not cost a lot to double that in the overall order of things. Another was, in a way, people who had more resources but who were having to draw down their capital. It was suggesting that you could increase the capital threshold so that at least people would feel they had something to preserve in a worst case scenario. Again the cost of doubling it was significant.

**Q275 Chairman:** Lifting the threshold of capital has happened over several decades now, has it not in a sense?

**Mr Hirsch:** I have not studied this. I am not sure whether it has lifted in proportion to people’s assets.

**Q276 Chairman:** It would be a significant lift.

**Mr Hirsch:** Yes. The other thing about it is that there are more people who are in that situation of having housing assets so the issue has changed. We also looked at how you might redistribute some of the money that goes to people with the highest needs, particularly in care homes. There is the strange situation where some people get everything under the continuing care criteria and others get next to nothing, even though they may have very high needs and we looked at the way that could be distributed either at zero cost or at low cost. We also suggested that more public support for equity release and possibly a scheme like student loans might actually cost very little and help people, particularly with high domiciliary care costs. I have to say I think personally that those arguments are fading or rather the more important argument at the moment is how you get the Green Paper issues sorted out. There are some similarities between proposals which went on the table this autumn as short-term fixes and what was being proposed there and I am not sure that is always helpful because if you are discussing two things at once it is very difficult.

**Q277 Sandra Gidley:** You said everybody agreed that there should be a contribution. Who is “everybody”?

**Mr Hirsch:** I did not say everybody. If I did, I spoke wrongly. There is general consensus. This was a deliberative process, a series of six public debates and discussions and all-day sessions with several hundred people involved. Some of them were actual users, some of them were carers, some of them were professionals working in the field. There has also been some opinion polling which has confirmed this. It always depends how you ask the question, but the idea that individuals should contribute something seems in all the studies and surveys I have seen recently to be something which the majority but not everybody agrees with.

**Q278 Sandra Gidley:** If we are going to have an 80% state-funded system that introduces the 20% with a huge amount of bureaucracy, would it not be simpler just to go the whole hog and have it 100% state funded?

**Mr Hirsch:** If it were the case that presently the state was contributing zero and we were debating whether to go to 80% or 100%, I would see your point. Actually we worked out that of those costs we were talking about the state is already contributing two
thirds. So if the individual is going from contributing one third on average—of course you have to have means-testing when it is that high—to 20% across the board, that would cost roughly half, slightly less than half additionally what it would cost to go all the way to 100%. It is a very different financial proposition for the Government. There is also a sense in which I thought people were being realistic saying the national care service is not the same as the National Health Service in that sense, it is something where we get some really strong guarantees that we do make a contribution. For the future, where you may want to increase the contributions in order to fund something better as people are more able to contribute, the precedent of saying “Look, this is not something where we are going to say everybody is going to get it free from now on” leaves you more room for manoeuvre than if you just say “From now on this is all going to be free” which could very expensive in the long term.

Q279 Sandra Gidley: You mentioned that there is a step in the increase in costs. Does that include an assessment of how much it would take to administer? Surely if everybody gets the universal benefit it is much cheaper to administer. How was that factored into your assessments or was it not?

Mr Hirsch: No, it was not. We are talking about billions of pounds here. We thought it would cost £2 billion and if you went the whole way it might cost £5 billion. It is not just an administrative issue.

Q280 Sandra Gidley: I think we will move on to the Prime Minister and a question for everybody. He recently made an announcement regarding free personal care at home for those with the greatest need. Has that been costed?

Mr Humphries: The figure that the Department of Health are quoting is £650,000 or in that region.

Q281 Sandra Gidley: It seemed quite low.

Mr Humphries: Yes.

Q282 Sandra Gidley: Suspiciously low.

Mr Humphries: I am not quite sure how you can arrive at a definitive cost for free personal care for people with the highest needs unless you define what is actually meant by those terms and those terms have not been defined. I think discussions were going on with local government about how it is implemented. I suspect the costings are more in the nature of a budget that the thing has to be financed through rather than what it will cost to give free personal care to people with the highest needs. That is my interpretation of it.

Q283 Sandra Gidley: Do any of you see any possible unintended consequences of the policy if it was put into practice?

Mr Humphries: Potentially several. The obvious one is that free personal care is free at home but not in residential care. That obviously makes it very di cult to create something which is edge in entitlement based on needs. If you never reach the level of need which would entitle you to that free personal care but you have a level of need just below it and therefore do not receive anything and you have had that level of need for five or ten

Q284 Sandra Gidley: That old chestnut.

Mr Humphries: Which begs the question of how many more efficiencies can local authorities produce to do these things and if it is so easy, why were they not doing it before? There is a lot that we do not know about this proposal and the crucial question is: how does it fit in with the wider package of measures proposed in the Green Paper, especially when the Green Paper told us we could not have free personal care because it was not affordable. Apparently this is. There is an incoherence there, is there not, which we have yet to understand?

Mr Hirsch: The biggest unintended consequence could well be to affect the scope for openly debating and considering in society what we want in the longer term and in particular whether these Green Paper options should be introduced. All the options do have an element of this idea that everybody pays some consistent amount across the board, that you have a regime which affects people in care homes, people with high levels of domiciliary care, people who need wider levels of support, possibly lower levels of support. What this seems to be saying is that here is a group of people with a particular set of needs who are going to get it free. First of all, that is pre-empting some money which could otherwise be spread across the system on a co-funded basis but it is also making it very difficult to turn your back on that. It is very difficult to create something which is then co-funded and say “Sorry, it's not free any more”. Another thing I should say about this Caring Choices consultation, which did involve a very wide number of organisations—I think 14 organisations involved—so it was quite a thorough consultation, is that people there felt very strongly that the way to go was not just to focus on the very high needs, that just as important was to ensure that people with a relatively lower level of needs, people who were vulnerable, people who might have falls in their home, that we should make sure they are getting what they need as well and a whole language of care consulted people in care homes, people with high levels of domiciliary care, people who need wider levels of support, possibly lower levels of support. What this seems to be saying is that here is a group of people with a particular set of needs who are going to get it free. First of all, that is pre-empting some money which could otherwise be spread across the system on a co-funded basis but it is also making it very difficult to turn your back on that. It is very difficult to create something which is then co-funded and say “Sorry, it’s not free any more”. Another thing I should say about this Caring Choices consultation, which did involve a very wide number of organisations—I think 14 organisations involved—so it was quite a thorough consultation, is that people there felt very strongly that the way to go was not just to focus on the very high needs, that just as important was to ensure that people with a relatively lower level of needs, people who were vulnerable, people who might have falls in their home, that we should make sure they are getting what they need as well and a whole language of care and support in the Green Paper seems to be about that; it is trying to look at it as a package. If you really just focus on what is high end need, that is the continuing care criteria I mentioned earlier, then you are distorting things. It does seem to me very odd in terms of its timing and it really seems to cut off a line of debate about what the whole system should look like.

Mr Lloyd: I would echo those comments. If implemented it will create some strange pernicious unintended consequences, for example this apparent cliff edge in entitlement based on needs. If you never reach the level of need which would entitle you to that free personal care but you have a level of need just below it and therefore do not receive anything and you have had that level of need for five or ten
years, then you will experience catastrophic care costs and you could burn through thousands and thousands of pounds without ever getting that entitlement to free personal care. So it will create some very strange inconsistencies and outcomes which will appear very, very unfair to people. I would also echo comments around the overall Green Paper debate, whether or not this was actually connected or is even coherent with the Green Paper and the difficulty down the line for any government saying to the public that they will have to make some sort of contribution towards long-term care, because the public has just registered the fact that it is actually going to be free. Indeed it reinforces the point that is often made in these debates that this is an area that absolutely requires political consensus. 

Even before we start putting proposals to the public there has to be an absolute political consensus. You cannot have reform arriving from political debate. We need people to be able to trust that if they are going to buy into a system, that system will not change with a change of government.

Q285 Charlotte Atkins: There has been criticism of the Green Paper, that it fails to set out clearly or in detail what the funding options will actually mean for service users and particularly in relation to working age people. Would you agree with that criticism or do you think it is unfair?

Mr Humphries: We touched on this in an earlier answer. The detail is not there. I have some sympathy with the authors of the Green Paper because Green Papers inevitably are aspirational documents; they are trying to set out broad options in the direction of travel rather than specific detail. If they go into too much detail, people then criticise it saying they have made up their minds already. If it is too general and too much principle, people will say, as they are on this occasion, “Where is the beef and how can we understand this?” It is difficult to look at the impact on individuals, especially for working-age adults because of what we said earlier about the default assumption being that they will continue to get it through general personal taxation and the obvious inappropriateness of insurance-based options. Some of that is about language quite frankly and it could be clearer what the position is for working-age adults. We will not be able to make a confident assessment of what the impact would be for individuals until the Department publishes the underlying data and the modelling.

Q286 Charlotte Atkins: Do you think it would be easier for people to understand if there were actually two separate systems, one for older people and one for working age people?

Mr Humphries: In terms of simplicity across both groups, the simpler system would be a system which is based on free personal care through general taxation because that applies to everybody. There is no reason why you could not combine that with some sort of insurance option for people with high assets and wealth.

Mr Lloyd: It was my understanding from the Green Paper that, from the perspective of users, both working-age people and retirees would be using this national care service. From the perspective of the user they will be interacting with it in the same way. The question is just about levels of funding, where the funding comes from and entitlements. As it is, the majority of working age adults in receipt of care do have it funded by the state because typically they are in low-income households.

Mr Hirsch: For me the answer to this question hinges a lot on how attracted one is to measures which harness the assets of older people either on a voluntary or a compulsory basis, as the second and third options in the Green Paper suggests. The implication is that people have to pay for their accommodation anyway, they are moving into a care home so you would expect them to pay for their accommodation but the actual accommodation costs within a care home are more often than not a lot higher than those people have left behind. Is there not another way of looking at this and that is to say not an accommodation cost but an accommodation charge? You could even make that based in some way on the rental value of the home you left behind so that you give people the option of using their resources that they have been using for accommodation for the same thing. Similarly with food. It certainly would not look right to have a system which provides everything to people when previously they would have been paying for those things, food and accommodation, but if you could have a charge based on what people can pay then you would not have this issue. The evidence in Scotland was that people often did not quite understand and were perhaps rather surprised by the fact that they still had to pay part of the fee because they thought that free meant free. You have to be honest with people. The really important reason, the attractive reason for saying “We will make a charge for accommodation which people are able to afford without running down capital” is that then makes the deal of the second and third options a bit more attractive. The deal is really that you effectively give up a certain amount of your inheritance but it is a known amount and in exchange that is all you will have to pay. That deal falls down if people feel there is still a risk that they are going to have a lot to pay on the extra cost of accommodation that they would not have been paying in their own homes.
Mr Lloyd: I definitely echo that. It does not make sense to push through an enormous reform, to pool the risk of personal care costs and then just to ignore the potential accommodation costs which can also be catastrophic, which can also use up a lot of people’s resources. A next stage perhaps for the Green Paper is to think what kinds of options would be available to deal with that and it might be that you have some level of optional or subsidiary insurance to insure yourself against potential hotel costs in addition to personal care costs. If we were to go down the route of a state-sponsored insurance scheme as the Green Paper outlines, you could have the main scheme for personal care but alongside it have some extra optional insurance for hotel costs. Or indeed it might be something for which the private sector would be able to develop a product, if personal care costs had been taken care of through a state-sponsored scheme.

Mr Lloyd: It depends on you anticipating that you may well go into residential care and recognising that you will have to pay for it yourself and then wanting to insure yourself from catastrophic costs for hotel charges.

Mr Lloyd: I would refer you to the PSSRU as probably the best place.

Mr Hirsch: It is very hard to estimate. We should not exaggerate this. Even though often the accommodation costs can be up to half, although it is very difficult to calculate, you must remember that people do have considerable resources from their pension and from renting out their home to go towards that. Certainly in Scotland the policy has been popular. Most people probably do not have to sell their homes. The problem is that it remains a big risk and this is about protecting against risk. So even if a minority of people in care homes have to do it, there are very few people who lose anything like all their inheritance because sadly when people move into very expensive options often their life expectancy is not great. Even if it is not many people, it is about protecting against that catastrophic risk. I am suggesting that the way round would be to have a scheme which does cover everything. It covers the fee, minus a charge. The alternative is having two systems: a system which covers the fee but they charge you something and get something back according to how much you can really afford to put in on a recurrent basis to pay for accommodation.

Mr Hirsch: Quite a lot of people have to sell their homes. There is a big confusion between this idea about running down inheritance and selling your home. If you have a home worth £300,000 and that is being taken into account and you simply do not have any cash and you do not like the terms of equity release, you do not need to use your home any more. You may well end up selling it but whether you use up £10,000 or £20,000 or £300,000 of that, I think there are very few people who would use it all up because of the length of stay.

Mr Hirsch: There are issues here about policy and there are issues here about perception and I suspect it is the latter category which is the one we have to address very substantially indeed. We have argued consistently that there is a case for looking at absorbing Attendance Allowance within a care budget provided that there are some very strict guarantees around that in terms of protecting existing payments and making sure that we do not replicate the Scottish experience where the Attendance Allowance money did appear to have been lost to the social care funding system. The problem at the moment, because the detail is not there, is that people see this as a potential loss of something that is valuable and important to them and that is entirely understandable. If you are getting a regular payment into your bank account every week from the taxpayer, you are not going gladly to give that up on the back of some promise about a bright new future for care funding. People, quite rightly, will want some assurances and clearer explanations about what the money will be used for and how it will enhance the future service rather than it just being a reduction, something that is taken away. Some more detailed work needs to be done on this.

Mr Humphries: There are issues here about policy and there are issues here about perception and I suspect it is the latter category which is the one we have to address very substantially indeed. We have argued consistently that there is a case for looking at absorbing Attendance Allowance within a care budget provided that there are some very strict guarantees around that in terms of protecting existing payments and making sure that we do not replicate the Scottish experience where the Attendance Allowance money did appear to have been lost to the social care funding system. The problem at the moment, because the detail is not there, is that people see this as a potential loss of something that is valuable and important to them and that is entirely understandable. If you are getting a regular payment into your bank account every week from the taxpayer, you are not going gladly to give that up on the back of some promise about a bright new future for care funding. People, quite rightly, will want some assurances and clearer explanations about what the money will be used for and how it will enhance the future service rather than it just being a reduction, something that is taken away. Some more detailed work needs to be done on this.

Mr Humphries: I very much hope that will not be the case. It seems to me that if we want to have a radical debate about how we pay for care in the future, then
it is difficult to say that this is sacrosanct and we cannot look at that. There is clear evidence that a large chunk of that £3.5 billion, whatever it is, Attendance Allowance expenditure is going towards care needs. People also complain that funding for different streams of funding and care are fragmented. Bringing AA into a personal care budget stream does offer an opportunity to simplify that.

Q293 Dr Naysmith: So you are not saying the Government should avoid this minefield altogether?  
Mr Humphries: No. There is a lot of money here.

Q294 Dr Naysmith: What sort of reassurances and cast-iron guarantees should the Government give?  
Mr Humphries: I think there need to be some detailed proposals in the White Paper stage about how the funding streams for a proposed national care service would be made up, where the money would come from and, in particular, how you would avoid the inevitable fears that people are going to have that where you move from an entitlement based approach, which is what you have with Attendance Allowance, once you put that money into what is in effect the cash limited local authority budget, that in fact it will make a reduction in years to come.

Q295 Dr Naysmith: So we certainly need a guarantee about that.  
Mr Humphries: Yes and that is the crunch issue which the architects of the new funding system have to address so that people will be satisfied on that score.  
Mr Hirsch: I agree that you should not make this thing sacrosanct. People always will object when something which is known and they are receiving already is being threatened and that is understandable. There are three differences which would need to be addressed and the Government are talking about a system which gives care and support. I would have thought that the ambition was to create something which does a lot of what the Attendance Allowance already does. There are three aspects to that which need to be addressed if you are going to reassure people. One is an entitlement but it is an entitlement regardless of what else is going on in your home and in your life. So you receive Attendance Allowance whether or not you happen to have somebody who is going to do it for free living with you, whereas the local authority support that people are getting does look at your situation in that sense. It has become more an entitlement-based system. The second thing is about releasing more choice in the main care system. If you could move a bit further and show that there was flexibility to use it, which if not complete freedom was at least helping people to spend it on those things on which they are spending Attendance Allowance now, that would be a reassurance. The third thing which is greatly neglected is the issue about assessment and what kinds of needs you are really supporting. At the moment, with rather strict, narrow eligibility criteria, the care system is not supporting these lower levels of need. It seems to me that a corollary of bringing Attendance Allowance in is that you do have to lower those criteria and be willing to start funding people who do not have quite such a severe set of difficulties. The problem is that the illustrative costings that are being used in the Green Paper are really based on what is being spent now within the care system. They say it would cost £30,000 roughly over somebody’s life to fund their likely care from age 65. I think it is likely to be more than that if you bring in these extra needs. So certainly the suspicion that what the Government are doing is to try to have a cost neutral thing by bringing it in just does not seem to be sustainable.

Q296 Dr Naysmith: What is the difference? The Government have ruled out Disability Living Allowance and said it will not be affected. What is the difference between Disability Living Allowance and Attendance Allowance?  
Mr Hirsch: Obviously it is partly to do with the age. They are focusing on a system which is providing for people over 65 which, unless you have a continuation of DLA, may mean Attendance Allowance for that.

Q297 Dr Naysmith: Similar sorts of arguments apply to DLA, do they not, if you can give the cast-iron guarantee that nobody is going to lose out and that sort of thing?  
Mr Hirsch: Yes.  
Mr Humphries: Yes.

Q298 Dr Naysmith: It does seem a little bit strange that one has been protected and the other one has not.  
Mr Humphries: There is slightly stronger evidence of the correlation between what people use their DLA on in relation to need and the extra income costs of disability, whereas with Attendance Allowance it is much more oriented towards care costs rather than living costs arising from disability. That is the crucial difference between them.

Q299 Chairman: In this session we have gone across all the tensions that there have been about the funding of long-term care for many, many years now. We had a Royal Commission in 1999. We have had two reports from Derek Wanless plus other reports that you have been involved in as witnesses yourselves. Are we any nearer solving this and getting a resolution to this problem?  
Mr Hirsch: We are nearer in the sense that there is official recognition that there is a problem to be solved.

Q300 Chairman: How long did it take for us to get there?  
Mr Hirsch: We are nearer, having moved there very slowly. The crucial thing is about releasing more resources and there is a slight difficulty in that we do not have any money in the public coffers. There is a
rather ingenious-sounding solution helped by the kinds of scheme which James has developed of releasing equity from homes in that way. The real question is whether we have the courage. Are we willing as a society to go with one of those options? It is about whether we are willing to bite the bullet and raise more public resources, more resources for the system in this kind of way.

Q301 Chairman: Do you agree with that James?
Mr Lloyd: Yes, to an extent. The debate has advanced enormously. The policy wonks, some of whom are here today, have been busy working away for the last few years and have developed models, developed arguments, done research. Enormous progress has been made. The fiscal situation is problematic and it will affect going forward how much public funding can be put into social care. In a sense, ultimately when we are talking about old people's long-term care, this is actually about private household wealth and how that is used and how the Government give people the opportunities to use the wealth that they have. It is very important to have a clear picture of where we want to go to in 30 or 40 years and to make sure that we are all agreed on that and that we make sure that whatever steps we take now, whatever route we take now, ultimately goes to a place we are all agreed on which I believe will ultimately be working-age contributions towards long-term care insurance. The other big issue, which I probably have to make, a point I made before, is that everybody in this debate, even the lowest-paid care workers recognise that there has to be long-term political consensus. In effect this is a non-partisan issue; it is like pensions. Unless there is political consensus you will not have any reform. For some of us then the recent announcements around the party conferences were a little bit frustrating because they almost suggested that while everybody in this debate realises that it is a non-partisan issue, the politicians perhaps do not. It is useful to have a forum like this which is cross-party to air these issues and for everybody to recognise that when you have these conflicting proposals ultimately it is just going to confuse the public and push reform back and it is not actually meaningful. The critical point I would also make is that we have to be realistic that this is never going to be an issue which will really be a vote winner. It is never going to be a way of accumulating political capital, it is going to be a government which says "Right, we've got the agreement, we've got the political capital to expend, we're going to take the difficult steps to reform the system". One way or another we will all have to pay more at some point in our life course if we want to have a decent long-term care funding system. Those of us in the policy world and research world are doing what we can. Whether those in the political world are doing what they can remains to be seen.

Mr Humphries: I would endorse that. I would just add that some of the political noise around this is the price that we have to pay for moving it forward. I would much rather have a Prime Minister saying anything about social care than saying nothing whoever that Prime Minister is. This is my 33rd year working in social care. We are probably closer than at any point I can remember to a point of recognising the need for radical reform. The momentum must be maintained. The problems we have been addressing this morning are not going to go away whatever the outcome of the next election or whatever. We must keep this on the agenda.

Chairman: On that note, may I thank all three of you very much indeed for coming to help us. We will see whether our report has any influence in spheres where yours do not. Thank you very much.
Witnesses: Baroness Young of Old Scone, a Member of the House of Lords, Chair, and Mr Ronald Morton, Strategy Development and Innovations Manager, Care Quality Commission, and Mr Sampson Low, National Policy Officer, UNISON, gave evidence.

Q302 Chairman: Good morning. Could I welcome you to what is the third session of our inquiry into social care. I wonder if, for the record, I could ask you to introduce yourselves and the current positions that you hold?

Mr Low: Good morning. I am Sampson Low; I am a policy officer with UNISON, the public service union. We represent 300,000 members in social care in caring, administrative and professional social work capacities for a wide range of employers—local authorities, NHS, private voluntary sector and agencies—across all 152 local authorities in England and members in Scotland, Wales and Northern Ireland too.

Baroness Young of Old Scone: My name is Barbara Young; I am the Chairman of the Care Quality Commission, the new joint regulator for health and social care.

Mr Morton: Good morning. My name is Ronald Morton from the Care Quality Commission. I am a strategy manager within the Commission.

Q303 Chairman: Welcome once again. I have got a question for the first two of our witnesses to start this session. Obviously we are doing an inquiry into the Green Paper “Shaping the Future of Care Together”, which is concerned more with funding options for social care and with improving the services provided. How widespread is poor quality social care and could you give us some examples of that?

Baroness Young of Old Scone: Shall I start off, as it is the heartland for us, I suppose. The latest figures we have got are that about 79% of social care services are in the good or excellent category, about 16% are in the poor or adequate category, which is about 3,700 services, and that is not acceptable, so there needs to be action on these poor providers to get them further up the quality spectrum. Generally speaking, performance has been improving for particularly residential care services over the last few years and performance against the national minimum standards has risen in the figures we will be launching at the back end of this month for six years in a row, so I think there are some real signs of improvement in some services. There are some areas, however, that are unacceptable, particularly that 16% of poor and adequate services. There are some major questions about domiciliary care, as opposed to residential care, where, I think, there has been less focus in the past and there needs to be more focus in the future. Of course, the quality of care can be poor even in a good care setting, and there will be occasions when things go wrong, and one of the key features for the Care Quality Commission is that we want to hear those accounts of poor quality care, because if we can understand how people are experiencing care, we will then adjust the way in which we regulate providers of care in order to make sure that we are focusing more closely on places where people feel they are experiencing poor quality care. So we are very keen to get the views of the users of services really at the heart of our work on regulation. Of course, a big element of the quality of care is not just how the services are providing care but also how the commissioners of care are commissioning care, and we can talk more about that if you want.

Q304 Chairman: We will want a little bit more detail, yes.

Mr Low: Obviously we can give bad practice from the point of view of our members in terms of pressure on pay and conditions, particularly in home care or domiciliary care, but a classic example of bad practice in home care and social care is the contracting system where the local authority is under pressure to take the lowest possible price and bid for work regardless of quality. Obviously, the contractor bidding is bidding to abide by the Care Quality Commission’s minimum standards, but often, frankly, the contracts are awarded at unfeasibly low levels, and that puts enormous pressure on the workforce and many providers then do not complete their contracts, find that the cases, the individuals and users have far more complex needs than they ever imagined and start trying to hand back the more complex cases to the local authority, or even finish the contract and hand back to local authority who has the ultimate duty of care. So cut-price contracting is, for us, perhaps a classic example of bad practice in the social care sector.

Q305 Chairman: Baroness Young, you did say that inspections show quality ratings are improving; I think you said something like a six-year one. Does that reflect genuine improvement? It does beg the question, are your inspections any better than Ofsted’s inspection of Haringey’s Children’s
Services, which were found to be, effectively, in a position where false data was being used to say that everything was okay? Are they?

Baroness Young of Old Scone: Clearly, I would not want to comment on Haringey other than to say that the particular issue there was child safety.

Q306 Chairman: It is the quality of the inspection, I suppose, that we are talking about. How do we know that it is good quality as opposed to (I hate to use this expression but I am afraid it does happen, certainly in health) this tick-box exercise that organisations go through?

Baroness Young of Old Scone: I have been very impressed, in the 16, 17 months that I have been associated with the Care Quality Commission, with the quality of the inspection of services, but, as you know, we have got a new registration system coming in and we are particularly keen to build on the expertise that has been developed over time in inspecting services to make sure that the inspection process is as effective as possible and focuses on the things that people really care about—the outcomes, whether they are treated with dignity and respect, whether their rights are respected, as well as a whole variety of other issues—and we want to put much focus on whether the care that people get is what they should have the right to expect, in terms of what it does for them, rather than simply looking at processes and policies, which can lead to a bit of a tick-box approach. That has caused a bit of a stir in the social care world, because in the consultation we undertook on the compliance criteria that we are going to use for the new registration system quite a lot of providers came back and said, “No, no, please tell us what to do”; whereas we have been saying, “This is the outcome we want you to deliver and we do not have strong views about how you deliver it, but we will have strong views about whether you are delivering it.” So I think there is going to be quite a lot of discussion about how we can make inspection as effective as possible, bearing in mind that some of the bigger providers will have good systems for managing their own quality and some of the smaller providers will need more help because they have not got the internal capacity to think through some of the issues of how they go about providing the outcomes that we are looking for. The other side of the business of assuring quality is, of course, the work that we do with councils reviewing how they commission services and how they put in place mechanisms to make sure that the range and quality of services that are available for people, whether they are people funded by the council or whether they are self-payers or people who top up payments, whether they are a good range, whether they are accessible and whether they are good quality.

Indeed, I think we have an effective process of working with councils to identify the ones who are not commissioning as well as they should and whose range of services across the piece, therefore, is likely to be less good. We meet with them on a regular basis, we develop joint action plans with them, we monitor whether they are achieving those action plans and, I think, there has been a track record which CSCI, our predecessor, developed and took forward of getting more councils up the quality spectrum, as it were, in terms of their commissioning role. So we can get at the services in two directions: both from the commissioning point of view and from the service provision point of view. Clearly, because we are not on every door step all the time, there will be times when things go wrong in particular care settings that we perhaps should have anticipated and did not or that we could not have anticipated. One of the pieces of work we are doing at the moment is what are the pre-conditions for poor quality? What are the things that happen in services that make you worry that they are going to be at risk of providing poor quality? There is a good body of research evidence from other regulatory fields that says that things like change of manager, high staff turn-over, change of owner, major cost reduction programmes, all those sorts of things, are likely to make a service more prone to poor performance, and we want to try and identify those indicators of incipient poor performance so that we can move in and help nip things in the bud. There is a lot of work ongoing on our regulatory processes at the moment to try and build on the very good work that CSCI did and improve them further.

Q307 Chairman: As opposed to looking (and this is your statutory responsibility) at what individual councils do (and it is right and proper that you should do that), does the CQC have features of what you believe is a quality service as well?

Baroness Young of Old Scone: We think a quality service is one that really puts the individual at its heart, that is designed to meet the needs of that individual, that has the individual in the driving seat with their carers and their family and that really delivers the 16 criteria that we have got in the new registration system, which range across a whole variety of safety, well being and quality issues, but the quality of the service is not the only thing: because there has also got to be quality of access. If you cannot get at a service, it is not a high quality service because you are not able to get it. So we believe that access to services is as important as the quality of the service that you ultimately get, but certainly having people right in the driving seat of their own services, for us, is a fundamental part of quality.

Q308 Chairman: Sampson, do you have view about this?

Mr Low: Yes. Just on the inspection and star-rating system, while we appreciate the CQC move to monitoring outcomes and quality rather than processes, the stipulations they make in minimum standards on staffing ratios and NVQ qualifications are particularly useful for the workforce and we would not want to see that dissipated, because we feel that that is a useful pressure point for trade unions, and others, to intervene to try and encourage workforce training and safe staffing ratios. So in some respects we do like the process elements of the current inspection system.
Q309 Dr Stoate: Baroness Young, we have already heard this morning that funding is a big issue and driving costs down to the minimum is bound to have an effect in some areas, but 16% of adequate or less than adequate is pretty alarming. How much of it is just down to funding and how much of it is due to other factors, such as poor commissioning or inadequate training of staff? What other issues do you think are involved?

Baroness Young of Old Scone: I suspect that all those issues that you have mentioned play a role, and others as well. I think, generally speaking, poor quality services can result from either chaotic and not very well managed services, of which there are some, it can result from huge pressure on resource as a result of councils and individuals not having as much money as a result of the recession and of downward pressure on fees. One of the big questions for me is, if you have got a local authority that is commissioning services at a very low fee level where you have got somebody being looked after for £400 a week, or something like that, is it possible to provide a quality service at that level? That is a big question for me because, obviously, that starts to bear down on issues like the amount of money you can pay staff and the skill mix and level of staff that you can provide, and these are very fundamental, important issues in terms of the quality of care. Taking the staffing issue, if we do not have well-trained staff, well-motivated staff, who see looking after people as a valued part of society and as a profession, we will end up with some of the poorest paid, least motivated staff looking after some of the most challenging and important folk in our society. So there are big issues about the downward pressure on costs. I think there is also an issue that is about inappropriate behaviour that starts to grow up if there is real pressure on finance, with cost shifting between health and social care and people inappropriately placing individuals, inappropriate, for example, domiciliary care, because it is cheaper when, in fact, some other setting that is more expensive might be a better setting for that person, and, of course, there will be pressures on people who self-pay, and they have got less money at the moment. There are some real opportunities, however. If you look across health and social care, there are some real opportunities to try and re-engineer the way in which the pathways of care operate, to try and get more money into the prevention and promotion end of the care and into the least expensive parts of the care pathway and try to avoid inappropriate admission into secondary care, inappropriate re-admissions, inappropriately delayed discharges, to try and make sure that health and social care are working together to get the most effective pathway of care for an individual that is at the most cost effective level. That, in itself, I think, means that joint commissioning and pooling of budgets is a fundamental part of the future. I just do not see how, in an economic squeeze, we are going to be able to provide effective care unless local authorities and PCTs start to jointly commission and start to pool budgets to avoid the boundaries between health and social care locking folk into the wrong part of the pathway.

Q310 Dr Stoate: That is helpful. We have established—it is well-known—that your members are amongst the lowest paid of any group of workers in the country. How much do you think that poor quality of care is down to, effectively, very low wages, or do you think there are other issues, such as poor management and poor training?

Mr Low: Often it starts with under funding and, as I said earlier, some cut-price commissioning, and that puts pressure on wages and conditions, but also managers’ pay and conditions and the resources for training. Our home care, domiciliary care staff say that they are often, over the years, taking on tasks previously done by the district nurse, but they are having to do this in shorter and shorter time slots—15 or 30-minute time slots—and building a relationship with the users is often the thing that gets squeezed. It is the sort of thing which, I know, is hard to quantify, but I am sure members of the Committee appreciate that having continuity of care—regular home carers who can also build a relationship, ask about family relationships and check on other things as well—provides early warning for public services.

Daily contact from a home carer can alert problems with not being able to pay fuel bills or other problems, and some of the unofficial side of the social care job, frankly, gets squeezed and, they say, it is difficult to do dignity in 15 minutes.

Q311 Dr Stoate: I entirely agree with you. Baroness Young, you mentioned earlier that the quality of the service is largely dependent on whether or not you can actually access it. In other words, if you cannot access the service, it is difficult to call it a quality service. What do we know about levels of unmet need? Is there anything that we can say about people who do not even receive a service at all?

Baroness Young of Old Scone: There is not really a clear estimate of unmet need, but CSCI, our predecessor body, in its State of Social Care Report 2007, reporting on the year 2006–07, reported that shortfalls of care were particularly high in that group of people with moderate to low care needs but also that a number of older people who receive no services but have no informal care to compensate for that, despite having high care needs, were at risk.

There were about 6,000 people in that category, about a quarter of a million people not ostensibly in receipt of any care at all, with less intensive needs, but, nevertheless, real needs. So there is a sort of informal estimate of what the unmet care is. Our summary really would be that for people who do get over the threshold and into care, the quality of care is improving, but the folk who do not get over that threshold are in a worse situation.

Q312 Dr Stoate: How can you then say that, effectively, 84%, or whatever it is, of services are good or better if there is at least a quarter of a million people who are not receiving anything and should be, by your own standards?

Baroness Young of Old Scone: Which is why we have now developed a model of care which has got six parameters to it, one of which is access: because though you can be, if you get access to services, in
receipt of a good service in terms of our inspection of its quality, nevertheless, if you are not getting access (and there are too many people who are not getting access to services), that is not a good quality of care.

Q313 Dr Stoate: Without a really good model of unmet need, you cannot possibly know the answer to that.

Baroness Young of Old Scone: Ronald may want to comment on this, because he has got more knowledge of what CSCI in the past did to look at this area. Certainly that is the most recent information we have got in the State of Social Care Report 2006–07.

Mr Morton: There is no clear or systematic estimate of the level of unmet need, and I think something would need to be done to explore what the levels actually are out there.

Q314 Dr Stoate: I thought it was rather basic. Should we not be doing that automatically?

Mr Morton: I think that is a very good question and a good challenge. I am not sure if it is the role of the regulator necessarily to look at that particular aspect, but I think that piece of work does need to be done to find out how many people are out there whose needs are not being met. Certainly, in the context of personalisation, there are needs which need to be met and people do not necessarily have the funds to pay for them, where they are screened out of eligibility to care.

Q315 Dr Stoate: I would say it is very much the role of the regulator. It is easy to provide care to a few people; is there whether there are a lot of people that ought to be getting it and are not?

Baroness Young of Old Scone: Some of the modelling that the Government ostensibly has done to establish the basis of the Green Paper is where that whole question of future needs, and future funding to meet future needs, needs to be addressed, I think. It is a much bigger issue than simply regulating the quality of care. Certainly, we will happily take on board the question of whether periodically in our State of Social Care report we should try and make an estimate of the unmet need, though I have got to make the caveat, I think, that Ronald would agree with, that the figures in the State of Social Care Report 2006–07 were so much hedged around with ifs and buts because they had to be assessed. They were guesstimates really.

Dr Stoate: Thank you, Chairman.

Q316 Mr Bone: I apologise to the witnesses; I have to go after the question. It is not the result of what you are going to say that is making me leave, though it might be! Mr Low, you talk in the memorandum about poor quality partly being about under funding and also about the profit motive in the private sector. Is not that just union claptrap and your pre-ideological views on this? What hard evidence is there that the profit motive in the private sector is driving down care?

Mr Low: The evidence is that it is cut-price contracting which is driving down quality. The profit motive is one factor of many—underfunding. I think, being the principal one—but, put plainly, the profits for shareholders are funds that are simply not available for care and if services are further subcontracted, as they often are, to other providers, agencies and others, then there is a sort of second and third tier of profit margin that has to be found. So it is simply really that this is money that is not available for care.

Q317 Mr Bone: So it is, in fact, your pre-disposed anti-private sector pro-profit motives, which I think devalues your comments. Many of the comments you say are very good, but in the world that I live in there is a family care home which wants to look after its employees, wants to pay them a decent wage and wants to look after the people in the home: the problem is that the wretched council is not increasing the funding to them. If you have no funding increases, how on earth do you keep the quality up? Is not that the problem? It is nothing to do with profit motive. You talk about cut-price contracts. Is not that the basis of it? If the council is saying, “We are not going to pay you any more this year”, how on earth can they even maintain the current level of quality?

Mr Morton: It is principally the contracting process which we have the objection to, but our tendency is to find that voluntary sector providers do have better pay and conditions than private providers and that there is not quite the same pressure on pay, terms and conditions and time slots and other issues. On balance, that is the background, but we do share the point about under funding, and the Low Pay Commission share it too. In their last report they express concern about social care commissioning processes not taking account of the rate of the minimum wage or their annual uprating. The social care sector is incredibly diverse. There are small-scale providers who are struggling, medium-scale businesses, but also large providers, who are owned by multinational companies and even by private equity firms, who are making healthy profits.

Baroness Young of Old Scone: Could I break the habit of a lifetime and support UNISON slightly with some figures that we have got from our inspection processes about the comparative quality between council-run services, voluntary-run services and privately run services? I do not think the gradient is huge, and this is an art rather than science, but council services have got the largest proportion of good and excellent ratings at 87%, voluntary sector services at 80% and 74% for privately run services. So it is not a huge gradient, but it is a notable gradient. That is from our inspection work on the quality of services.

Q318 Mr Bone: It is very interesting that the inspection showed a different quality between whether they are council, voluntary or privately run, but the serious point I was just making is that I did not think, in reality, that it is this profit motive that is the problem; it is the fact that if you are not funding
properly at the beginning how on earth can you in any sector? In my area there are very few council-run units. So when you are talking about comparing like that, it would be interesting if that was because you were in different parts of the country, because different parts of the country get better funding. There is a lot more to it than I think just saying that these nasty people are trying to drive down wages because they are in the private sector. Thank you, Chairman.

**Baroness Young of Old Scone:** Chairman, I know that you are pressing on, but I have now deciphered the piece of paper that I was given about the issue that we dealt with previously on unmet need. Just one sentence: Of course, local authorities should be doing joint strategic needs assessments for the totality of their population, which is where the issue of unmet need ought to be quantified, down at individual local authorities working with their health authorities and other authorities.

**Chairman:** We had this debate last week. One of the major issues is, if they cannot provide, are they going to make these types of assessment, but we may look at that further.

**Q319 Dr Taylor:** Good morning, Baroness Young. In your memorandum to us you have expressed surprise that regulation does not really figure largely in the Green Paper. What should the Green Paper have said about regulation?

**Baroness Young of Old Scone:** I think what we would very much be looking for is an endorsement in the Green Paper of the kind of model that we believe regulation focuses on, ie, that regulation has a strong role to play in not only making sure that services are centred on the individual and focused on outcomes but also that in the process by which we assess local authorities, ie, are they doing a good job assessing what the needs for their population are and are they doing the job, not only the way that they procure services, but also in the way that they encourage the market in services to develop and, also, signpost people towards services even though they are not funding them—that they have this broader overview role to make sure that needs are met, however they are met, whether it is by public funding or by self-payment or by a whole variety of informal care means. I think that second point is one where the role of the regulator is overlooked completely. People see us as a bunch of folk who go out and inspect services; whereas I think our best contribution is really assessing the performance of local authorities as commissioners of services and as holding the ring in this sense of place that local authorities have to make sure that there is a range of services for everybody, even if they are not being paid for by the local authority.

**Q320 Dr Taylor:** Because the commissioners are responsible for the quality of care that is provided. **Baroness Young of Old Scone:** Absolutely, and also for making sure that there is enough service, even if it is not a publicly funded service, for making sure that people can get access to services and that they are signposted towards them and that they get a proper assessment process.

**Q321 Dr Taylor:** I welcome very much your new registration system, coming from April 2010. “It marks a change from regulation based primarily on policy systems and processes to regulation based primarily on outcomes.” To me, one of the weaknesses of the present system (and I am talking rather about on the health side) is that trusts have only got to answer the question that they have got a policy in place for producing a certain result rather than the actual result. You are going on to outcomes, and I want to know exactly how you are going to assess outcomes: because in health you either get better or you do not—that is easy. How are you going to assess outcomes in social care?

**Baroness Young of Old Scone:** In fact, it is not going to be that easy in health either, because there is a single regulatory system across health and social care and there is a range of 16 areas of outcome that we will want to look at, and we will be publishing in the next two or three weeks our guidance on each of these 16 areas which will subdivide them into a whole variety of outcomes.

**Q322 Dr Taylor:** When does that come out?

**Baroness Young of Old Scone:** It is coming out in about three weeks’ time. So there will be about 300 pages worth of guidance on what the outcomes are and how we are going to judge them, and beneath that there will also be subsidiary guidance, which will not have a statutory basis but will be there to help people who are providing services and commissioning services and, also, people who use services to understand what the best available good practice around it is. For example, in social care we will be looking at a whole variety of issues that range across safety and safeguarding, protection of rights and dignity, staffing issues, issues of nutrition, hydration—a whole variety of different areas of care—and underneath that there will be this more detailed signposting towards good practice.

**Q323 Dr Taylor:** Specifically, to pick on dignity and respect, how will you assess that?

**Baroness Young of Old Scone:** Let me give you an example. If we are looking at a service in a care home, we will want to talk to individuals living there; we will want to talk to their relatives; we will want to talk to the staff about their approach to dignity and respect. If we are looking at a home with people with dementia, who may not be able to tell us how they feel about it, we have a specific assessment tool, which is an observational tool, that allows us to sit with a group of staff and service users and assess whether, in fact, there is a real relationship between the staff and the individual and their views, even if they are not able to be verbalised, are being respected, and that has proven to be a very successful tool. It is called SOFI (Short Observational Framework for Inspection). So there is a whole variety of tools we will use to assess whether dignity
is being respected, including the very important one, which is what are the views of the users and what are the views of their families.

Q324 Dr Taylor: When you talk to the residents and their families, will your inspectors be alone or will they be with staff?
Baroness Young of Old Scone: Absolutely, and quite often we take with us an expert by experience, someone who has either been in receipt of services, and therefore can understand from the perspective of a user, or else, for example, I did an inspection last week in a home for a mixed group of elderly people, some of whom have dementia, and we had a carer with us who had looked after her elderly father and had had long experience of working with someone with dementia, and she spent time with the people, talking to them as individuals, while we did the boring stuff of working out whether the staff had been properly trained and whether the kitchen looked as if it was clean and stuff.

Q325 Dr Taylor: To me that is very encouraging, because I had a huge argument with CSCI when they got rid of their lay inspectors years ago, and there seems to me to be a great importance of somebody who is lay, in that sense, who might get more out of very shy residents.
Baroness Young of Old Scone: It is also hugely important in the area of people with learning disabilities or mental health problems, because unless you have experienced the real frustration of not being dealt with as an individual, you cannot really understand how that feels, and we get a lot of value from our experts by experience.

Q326 Dr Taylor: When we get this paper in three weeks’ time, will this tell us how much of the current national minimum standards are being carried over into the new system?
Baroness Young of Old Scone: We have got a process for mapping the national minimum standards against the new system, but I do not think we will be publishing that with the guidance. We could certainly show the Committee that, if they wanted it.
Dr Taylor: Thank you.
Chairman: I would appreciate it if you could do that.

Q327 Sandra Gidley: Baroness Young, what enforcement powers do you actually have to take action against services that fall short of expectations?
Baroness Young of Old Scone: We have a wide range of enforcement powers, but I think we should put that in context by saying we want to be an organisation that is seen to be about improvement. So our first step is to work with a service and its commissioners to try and get improvement, but if that is not working, or if the circumstances are sufficiently serious that we are worried that enforcement is the only way to get real action, we have got a range of powers, which range from a stern ticking off through to improvement notices. We have the capacity with the new registration system that we can exact fines, we can prosecute, we can apply conditions to their registration which mean that they have to achieve an action plan or they will lose their registration, we can suspend registration if it is sufficiently serious or, at the end of the day, if a service is simply not meeting standards that are acceptable, we can shut it down and remove their registration. So we have got a pretty flexible and wide range of enforcement powers under the new registration system, which, of course, does not come in until 1 April for the NHS and 1 October next year for health and social care.

Q328 Sandra Gidley: All of this is in the public domain, so if somebody has had a stern ticking off, is this a matter of public record?
Baroness Young of Old Scone: If we formalise a warning, it will be a matter of public record, but if we just take them behind the bike sheds and say, “Look, if you carry on like this we are going to have to start getting a bit more heavy”, I think that is part of the improvement process rather than part of the enforcement process.

Q329 Sandra Gidley: Would that be recorded in any way?
Baroness Young of Old Scone: After each full formal inspection we publish a report, and there will be a history of enforcement action on our website for each provider, but we want to expand the information we provide about services, both health and social care. Each provider will have what is going to be called a quality and risk profile, and that will bring together, in one place, hopefully in an accessible form, everything we know about the quality of that service, wherever that is gleaned from, from service users and their families, from the information that services provide us as part of the inspection process, from our own inspections, from other sources of information about the quality of care, other regulators, other quality bodies, and we want to bring that together into a quality and risk profile which will be available publicly so that both the users of services and those who want to choose services can have access to it, but, also, commissioners can use it for commissioning purposes and I hope providers will use it to benchmark their services against each other.

Q330 Sandra Gidley: So why, if somebody has had a talking to behind the bike sheds, should that not be a matter of public concern, if there are concerns? Should not the public have as much information as possible?
Baroness Young of Old Scone: I think it is matter of degree. If there is some minor issue that they have just not understood the fact that it needs to be resolved. Mostly, when we are going in, we are going in to be helpful and to help services that are struggling to tackle a particular issue, signposting them towards good practice, giving them a bit of support, and I think that when you cross over the line and start taking formal enforcement action, that is when it should be published. If we were to publish every time we have a conversation with a home
about something that needs to be improved that is just part of the everyday fabric of regulatory life, we would be writing novels.

**Baroness Young of Old Scone:** Not that we do not have any information, we do not have a responsibility for the investigation of complaints. We expect the provider to have a proper complaints process and to be able to tell us what complaints they have received, but we do not have a responsibility for investigating them and making sure that the person who complains gets satisfaction.

**Q333 Sandra Gidley:** You could say the situation is a lot worse than you actually describe there?

**Baroness Young of Old Scone:** No, I do not think so. Obviously, the importance for us is making sure our inspectors are well trained and consistent so that everybody is getting the same sort of judgment, because regulation is not a science, it is an art. There is a lot of judgment about what is a serious and notable problem that ought to be publicised and what is actually just, “If I were you, I would do this differently”, and, “Joe Bloggs up the road does it pretty well, you might want to go and look at it.” It is all part of the ongoing process of working with services to improve them, and it may not just be poor services, it may actually be good services could become even better.

**Q334 Sandra Gidley:** You expect them to tell us what complaints they have received.

**Baroness Young of Old Scone:** We expect the provider to have a proper complaints function. If somebody complains about a care provider and the complaint is against the manager of those services you actually ask the manager to look into the matter and produce the report.

**Q335 Sandra Gidley:** Do you receive all the complaints information from different sources?

**Baroness Young of Old Scone:** As of the establishment of the Care Quality Commission, we do not have a complaints function. We are not responsible for the investigation of complaints. If somebody complains about a service, we will direct them to where they can take that complaint. The complaint, in the first instance, ought to be provided to the service to see if they can get satisfaction. If they cannot get satisfaction, depending on the funding mechanism they have, they can either go to the local authority, if the local authority has contracted for that service, but what we would do with the complaint information would be to assess it against what we know about that service.

**Q336 Sandra Gidley:** Baroness Young, you just said that you did not have any information.

**Baroness Young of Old Scone:** That can be against what we know about that service.

**Q337 Sandra Gidley:** So the inspector would see all of those complaints and any from any other sources?

**Mr Morton:** Indeed, and they would take them into account in deciding how the quality of the service was performing. So it is part of the range of evidence we would take into account in assessing whether the service is good, bad, or what the risk is to people using that service.

**Q338 Sandra Gidley:** If there is a problem and everybody is complaining to the home and there are these other processes, how is it fast-tracked so that you go in there and help sort the problem? There seems to be a significant gap in the system here.

**Baroness Young of Old Scone:** I think there would be a number of ways in which that would be picked up. Hopefully, if there were a service that was not doing well, we would have already been able to assess that from the work that we do in other ways.

**Q339 Sandra Gidley:** The word “hopefully” does not give great reassurance, I am afraid.

**Baroness Young of Old Scone:** But, also, the local authority has a responsibility, if they are commissioning from that service, because under their contracting arrangements they have a responsibility for making sure that the service is of a good standard.

**Q340 Sandra Gidley:** When we have personalised budgets it is going to be even more disparate.

**Baroness Young of Old Scone:** I think there are huge issues about regulation in a personalised setting, because obviously many of the services that will be provided in a personalised setting might not be subject to our regulation at all. So I think there are some big issues that we are working through at the moment on what the role of the regulator in the personalised world is going to look like for the future.

**Q341 Sandra Gidley:** You have powers to shut down but, in effect, are they not limited by the fact that if you shut down a home there is often no capacity in the system to relocate the residents? Is it not the case that it is not really a power?

**Baroness Young of Old Scone:** It is a power, and it is a power that we use on not infrequent occasions. I think it is a useful power as a backstop to demonstrate that if people do not take strong action to remedy services, we can put them out of business, but the reality is that if we came to the conclusion that a service was so poor and had not responded, what we do is work with the users of the services and the commissioners of the services to look at what alternative provision there is and how the users of...
that service can be transferred to alternative care provision, or, if it is the sort of service where there is a reasonably fast turn-over, how we can move at a reasonable pace towards the closure of that service. Indeed, I was present at the closure of a service last week where we had worked with the local authority over a period of about four or five months to find alternative placements and for the local authority to get its head around the question of how were they going to ensure there was an adequate range of services for their population without that care home being in existence.

**Q342 Sandra Gidley:** So for four or five months people were in a substandard care home. Is that what you are saying?

**Baroness Young of Old Scone:** Obviously, if there were a care home that was so dire that people were hugely at risk or being served so poorly that we feared for their safety or their well-being, their health, we would take faster action, as, indeed, the local authority would, because they would need to find alternative locations for them. Where a care service is just consistently poor and we are not seeing any signs of improvements, we can move at a slightly slower pace, but, obviously, the aim has got to be to get a planned and careful movement of the individuals concerned because it is their home and their life that we are talking about.

**Q343 Sandra Gidley:** How many care homes have been closed down in the last year?

**Baroness Young of Old Scone:** We will have to provide you with that information.

**Q344 Doug Naysmith:** Barbara, your organisation’s predecessor, CSCI, made some recommendations about revising the eligibility criteria for social care. Can you tell us about them and how they differ from the changes that the Government is now recommending?

**Baroness Young of Old Scone:** I think the model that CSCI was promoting, and which we support, was very much that the concerns about the existing eligibility criteria are that they are being used simply as a rationing mechanism and, in many cases, not only are they being used as a rationing mechanism, but individuals who have got sufficient funds, who are likely not to be eligible for local authority funded care (and, indeed, in many cases, it is only those with the highest level of need that are funded by local authorities) were screened out immediately and, as a screen that prevented you from getting the universal access to assessment and advice and signposting and support.

Q345 Dr Naysmith: Do you think the Government’s proposals cover what you intended and what CSCI (and you say you now support it) and what you want, as opposed to merely what is in the Green Paper now? Do you think there is sufficient in the Green Paper to cover that?

**Baroness Young of Old Scone:** I think the Green Paper, at its most radical, would change that completely, because, obviously, there are elements there that are looking at what the universal level of service is that everyone should have a right to and how that should be funded. So to some extent that would take the place of the access criteria, but there is going to be quite a long time between then and now.

Q346 Dr Naysmith: Absolutely. This is a long-term vision, is it not, really?

**Baroness Young of Old Scone:** Yes.

**Q347 Dr Naysmith:** You are running an organisation which will want to do something about it sooner than that.

**Baroness Young of Old Scone:** Absolutely, and there is a requirement already that local authorities provide this universal assessment and it is simply not happening. So, in our work on assessing the quality of local authority commissioning, we will be banging away at that one, because we think that that is a fundamental piece of service that everyone should have access to. We are doing some work at the moment, a review.

**Q348 Dr Naysmith:** I was going to ask you about that. You say in your submission that you fear more rationing of services will not take place because of the economic circumstances that we are in now and that access will get worse before it gets better. Can you tell us about the review that you are undertaking to look at this?

**Baroness Young of Old Scone:** Looking at the access criteria and how they have tightened over time, basically, in 2005–06 of the 52% of councils restricted their access to that the two highest levels, which is substantial or critical need. As of 2007–08 that has gone up to 72% of councils only fund services for those at the two highest levels of need: substantial and critical. So there has been a tightening of the accessibility thresholds over the last few years. Last year it flattened out and did not change too much, and the indications we are getting from councils now are that they are not going to change them for 2009–10. We will be able to assess that at the end of the year, but you cannot help but feel, with the tightening the economic situation and all the pressures that there are of demography and costs, that the reality is that the only way local authorities will be able to cope is by tightening these accessibility thresholds even further.
Q349 Dr Naysmith: Is this what your review is going to look at, whether the 72% stay the same, or get lower or higher?

Baroness Young of Old Scone: Our review is going to look more widely than that. It is going to look at the experience of individuals on their first contact with the council. So, across a whole range of individuals, whether they are eligible for state funded services or not, and what experience they have. Did they get proper assessment, were they given support in assessing needs, in being signposted to the right sorts of services, in being given help and support and advocacy in choosing those services. So that is the sort of thing we will be assessing as part of that study.

Q350 Dr Stoate: Baroness Young, how much actual personalisation of care is currently taking place?

Baroness Young of Old Scone: I think the personalisation process is moving, but it is very, very slowly. More people are actually getting services that are focusing on their individual needs and where they are at the heart and in the driving seat. Indeed, there are a great deal of examples. As I have gone round the country I have seen some people whose lives have been revolutionised by being able to decide how and when and where they got their care.

Q351 Dr Stoate: The question is not that that is not a good thing—it is a good thing—but what I am saying is how much of it is happening?

Baroness Young of Old Scone: It is patchy. Some councils are at a very early stage. It varies between different groups of people. I think it is being addressed with vigour by groups of people, for example the younger disabled groups, but for older people and older people with dementia or anybody who has got a learning disability or communication issues, we have really got to make sure that, though they may not want to take direct payments, nevertheless, ways are found of helping those folk become the driving force in their own care.

Q352 Dr Stoate: I understand that, but are you collecting any data or evidence on how it is rolling out: rather than what is happening, how much of it is happening?

Baroness Young of Old Scone: I do not know the answer to that.

Mr Morton: The information we collect will explore how many direct payments, for example, are being given. There has been a growth in trend of direct payments. The latest figures show there are around about 90,000 people with direct payments. It is small but growing in the field of services. People who use services are reporting to us that the quality of services is better than it was. Indeed, Baroness Young referred to the better quality of care services, particularly home care services, people directing their own support.

Q353 Dr Stoate: That is fair enough, but in your evidence you said that the one-size-fits-all model is still particularly prevalent amongst the self funders, those under 65 and those below the eligibility criteria. What can we do to try and bring things into line with a more personalised set up?

Baroness Young of Old Scone: There is a strong requirement being laid on local authorities to move towards more universal personalisation, but we think that they need to put in place a whole range of measures to make sure that that happens successfully: for example, support and advocacy services to allow people to get support as they work through the process of putting together an individualised package and making sure that they are getting the right range of services, because that is quite taxing for an individual with a disability or with a health problem.

Q354 Dr Stoate: It is clearly very taxing, but it all depends on information, and reliable information. So what are you doing to ensure that people making these decisions, particularly individuals making these decisions, actually have access to reliable, good quality information?

Baroness Young of Old Scone: Certainly we will be providing information about the services that we regulate. I think this is one of the areas where, quite frankly, the role of the regulator in a personalised world is very unclear at the moment, because for many of these services that are informal, as it were, and more diverse, they will simply not be within our regulatory remit, and that is an issue that is increasingly going to be of concern. So I think the work that we are doing to look at what our role in a personalised setting is needs to happen, as, indeed, right across the regulatory field, but, of course, the main avenue we have for tackling this issue is through the work we do with local authorities as commissioners of services, because they hold the ring on the personalisation agenda, their responsibility is to drive that forward, and we can assess, as part of our assessment of local authorities, how much progress they are making on personalisation.

Q355 Dr Stoate: But you understand why we have been be pretty alarmed by something you have said then, which is that people on personalised arrangements making their own arrangements, you are not able to have much of a handle on that. That is very alarming.

Baroness Young of Old Scone: It depends very much what services they choose to use. If they choose to use a very informal set of services that are not currently part of the regulated process, we have no regulatory role in that. Our only role is through the work that we do in assessing the quality of commissioning and the local authority’s role as the driving force in taking forward personalisation and, hopefully, providing support and advocacy services that allow people to develop personalised services safely, and to help them with some of the nuts and bolts issues associated, for example, with direct payments, if they choose to take a direct payment.

Dr Stoate: I am sure we will look at that in more detail later on. Thank you, Chairman.
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Q356 Charlotte Atkins: UNISON and the Care Quality Commission, obviously, both support personalisation. Both organisations have raised issues around the sort of personalisation agenda, saying that service users want to be in control but do not always want to be an employer and control a budget. Would you say that the only way for service users to be empowered is when they actually control the cash? I will ask Mr Low to respond first to give Baroness Young a little bit of a break and let Mr Low get a word in edgeways.

Mr Low: Thank you. We do, for the record, yes, support personalisation, it has many benefits, but in the current under funded system it does over promise and under deliver, and often the amounts available through personal budgets, either those with the local authority personal budgets or the direct payment system, are too small to make an effective difference for people. What we would like to see is the in-house services and local authority commissioned services to be given the resources to be more flexible, and then people who wanted personalisation, but maybe did not want to take on some of the responsibilities and challenges of direct employment through direct employment of personal assistants, would have some options. We quite like, also, the option where some authorities are allowing a hybrid system where some can have a partial direct payment which they can self-direct but they can also have a partial personal budget where they can buy in off the local authority menu of commissioned services or direct provision, so they could keep some day care centre provision. So that flexibility is good and we would like more councils to do it. We would also like to draw to the Committee's attention that our local authority and our disabled members of UNISON did a joint trip to Sweden to look at personalisation and found that the Swedish system is that the local authority employ themselves a pool of personal assistants who can be directed by users of the service, and that takes care of the registration, barring and vetting, pay and conditions issues and takes on a lot of the risk of covering sick leave, maternity leave and other issues, and we would be very keen for the Committee to investigate that further, if they have time, and possibly, if interested, to recommend to the Department of Health that that would be a suitable area for a further pilot.

Q357 Charlotte Atkins: Does that also help with the issue of continuity of care? Obviously, one of the concerns is that if you are dealing with someone with disabilities or someone who is vulnerable in another way, continuity of support is quite important in that context.

Mr Low: Yes, a local authority pool of personal assistants would help with continuity of care and information sharing, and you would not have a multitude, possibly, of agencies, different providers, providing care and cover. So continuity of care is very important, and turnover rates are a lot higher. I think, CQC and the other regulators will confirm that turnover rates are a lot higher in the private sector, at about roughly 24% and about 10% in the statutory sector, and turnover rates do impact on quality of care too.

Q358 Charlotte Atkins: Mr Low, do you have any evidence within UNISON that service users are actually being pushed into direct payments rather than selecting that particular option themselves?

Mr Low: Not so much pushed into direct payments, but if they have chosen direct payments they are often unsupported, as I mentioned earlier. Some good local authorities will commission advice services for local voluntary sector groups to help those with direct payments, but it is often not done with a package of available support to call on for those with direct payments, but, also, the earlier stage before direct payments are personal budgets. We do find some pressure to hit targets for personal budgets, which is where a user of services can cost and itemise the care they receive from a local authority and can choose within the local authority menu. Elderly people, often with only two 15-minute time slots a day in the morning and the evening, are being encouraged to shift from the local authority arranged services to a personal budget, which on paper would mean that they have gone through this assessment process and have chosen to do that but, actually, they are getting exactly the same service through the personal budget as before but it sort of actually hits a target. So there is a pressure particularly on the personal budget area. Also social workers informally and anecdotally tell us that there are some quick wins to hit targets to be made by shifting elderly users of services on to personal budgets. That is slightly different from direct payments though.

Q359 Charlotte Atkins: Baroness Young, did you want to come in on the personalisation agenda. Are there any concerns that the Care Quality Commission has?

Baroness Young of Old Scone: One of our concerns would be that, because of the practical difficulties experienced by some people and inadequate services in support provided to some users by some councils, it gets a bad name. We do believe that personalisation and putting the individual at the heart of their care and in control of their care is a good thing, but it needs these support services to be provided in order to make sure that people, particularly those with more difficulty than others, are coping with that (particularly elderly people and people with dementia, people with learning disabilities) and are able to deal with it and do not feel that they are being pressurised into it without the right sort of support for them to actually make sensible decisions and be safeguarded in the process, and that is part of the work that we will be doing with the assessment of local authorities. Have they got these services in place? Are they taking the right steps to balance the opportunity, the choice, that gives to people who live in their patch versus the risks that it poses to them and, also, how are they going about making sure that the right range of services does exist, not just the direct care services,
but the support services to allow people to choose the sorts of employment services that Sampson talked about that allow people to not be overburdened by the fact that they are employers.

Q360 Charlotte Atkins: You have no evidence at the moment that people are being pressurised into taking up direct payments.

Baroness Young of Old Scone: I do not think that would be evidence that we would necessarily collect.

Mr Morton: CSCI report, in its last State of Social Care report, that some people were being given direct payments and councils were kind of washing their hands of them and they were left, basically, to fend for themselves. So the issue of ongoing support is a very real and live one, and I think that is one that we can perhaps look at, what ongoing support councils are providing to the direct payment recipients. On the point that Sampson made about the turnover rates, we know, people tell us, that people want good quality staff, but they also want the same care staff working with them. Just to give you some figures on the turnover, council turnovers in 2007–08 were 10%. For the independent sector it was 18% and in the home care setting it was almost 21%. So significant levels of turnover and significant work force issues there, and I think work force issues are one of the issues that the Committee may wish to look closer at.

Chairman: I am very conscious of the time. I am going to ask for brief questions and brief answers, if I could.

Q361 Dr Taylor: Baroness Young has really answered my first question. Personal assistants: if they commission services from provisional providers, you will have no ability of inspecting or controlling that.

Baroness Young of Old Scone: No.

Q362 Dr Taylor: So that is big snag of personal assistants, as they are at the moment. Sampson, again, you have covered some of the things I was going to touch. In your submission, you have talked about a bank of personal assistants being employed by local authorities, which seems really to me, on the surface, a very good idea. You have also mentioned a code of practice. What would that actually mean, if there was a code of practice for personal assistants, and the employment of them?

Mr Low: Not so much a code of practice for personal assistants, but the employment of personal assistants. We would like it to be compulsory on local authorities that there was this model code. It would not be compulsory, though, on individual service users. They could take note of it as they pleased, but it would come with the direct payments package, this model of terms and conditions and good practice in employment. What that then leads on to is that the local authority recognises that good employment practice does cost extra and that the model code of practice should be built into the commissioning process, and we would like to see that built into the commissioning process and the amount allocated for direct payments. In Scotland, again, as well as Sweden, I would like to draw the Committee’s attention to the Scottish example of the Scottish Personal Assistants Employers’ Network (SPAEN), which is very good. It is a tripartite body that brings together micro-employers, UNISON and unions and local authorities to draw up good practice guidelines agreed by all parties for exchange of views but, also, has set up now a mediation process to avoid employment tribunals.

Q363 Dr Taylor: I think you are also suggesting that personal assistants should be registered?

Mr Low: Yes. There are lots of registrations, obviously, from the Criminal Records Bureau to the Independent Safeguarding Authority for vetting and barring issues. We believe that personal assistants should undergo those checks, but the final decision should rest with the service user where the local authority’s duty of care is but the user has full information available to them. On General Social Care Council registration, though, we would be slightly more cautious. What we do want to see is a level playing field. At the moment, I believe (and you will hear from them later) the General Social Care Council are not currently going to proceed with pushing registration into domiciliary care. If they had done, we would have felt that they should have also done personal assistants too, to create a level playing field. I will stop there.

Q364 Dr Taylor: We are told that a service user who employs personal assistants wrote in a blog last year that unions were guilty of spreading propaganda that disabled people are naturally bad employers.

Mr Low: We would refute that criticism totally. I think UNISON is unique among trade unions in that we have since our inception active disabled members groups and disabled members involved in all levels of our decision-making, and they have been party to our consultation response, the submission that went to this Committee, and only last week several hundred disabled members gathered for their annual conference to quiz Jonathan Shaw, the Minister for Disabled People. So we are unique among unions in our decision-making and our involvement of disabled people in our structures and, as I said, a previous example in Scotland, we are also a practical organisation. We are more than happy to sit down and work out common solutions with micro-employers, disabled people who do employ personal assistants.

Q365 Charlotte Atkins: Mr Low, in your written evidence you said that direct payments cannot be used as an excuse to close down local services and that certain local authority services need to be ring-fenced. Can you give us some examples and explain how it is in the interests of service users and taxpayers to keep these services going?

Mr Low: We would like to see some support for good local services. At the moment it is a lot of smoke and mirrors to do with budgets, but we are getting daily reports of local authorities seeking to close day care centres, and they are saying it is because of the growth of personal budgets, not efficiency and
budget cut pressures, and the users of the day care centres in town halls and county halls up and down the country are leading protests and petitions about it. There are some critical services, good services and common collective services that need to be protected, which those with personal budgets and direct payments at some point might want to use as well. So I think the local authority has a responsibility for minimum service standards and some core and common collective services for a variety of different users which should be maintained. Day care centres are a good example.

Q366 Charlotte Atkins: Do you think that the personal budgets are used as a smokescreen to close down day care services?

Mr Low: Yes. In many cases the users of day care centres are very angry about this sort of smokescreen used by local authorities to propose the closure of day centres. What we would like to see, as I think I mentioned earlier, is a more hybrid system where they might be able to take a partial direct payment for some services they wanted to commission themselves but, also, could keep some of their budget with the local authority for services like day care centres and other services, and that hybrid approach I think would work well.

Q367 Charlotte Atkins: Do you think that, with personalisation, it is inevitable that some new services will be commissioned, others will be decommissioned and that is going to be part of the process, or do you think that facilities like day centres, inevitably, will fall by the wayside simply because people do not value the day centre in terms of the money that perhaps they will need to put into it to maintain their continued attendance at these day centres?

Mr Low: I think personalisation will lead to a shift in the types of provision available, without a doubt, but at the moment the local authorities are incredibly cash strapped. What we need is a process where day care centres can be invested in, can be made more flexible and used as a base for a variety of health and social care professionals servicing multi-purpose day care centres, not just servicing one group of the community but several different groups of users in a far more flexible format. I think there are opportunities there.

Q368 Charlotte Atkins: So you do not think the day centres have had their day and that they really ought to be closed down?

Mr Low: No.

Charlotte Atkins: Thank you.

Q369 Dr Naysmith: Both UNISON and CQC raise concerns about safeguarding vulnerable people from abuse when they are directing their own care. Mr Low, do you think that all service users should be offered a Criminal Records Bureau check of prospective employees?

Mr Low: Yes, we believe that all service users should be offered a Criminal Records Bureau check for anybody they might employ as a personal assistant.

It should not bar them from choosing them. I am aware Baroness Campbell of Surbiton invariably says that her best ever personal assistant was somebody with a criminal record. She never fails to mention that in many of the speeches she makes in the upper House. We do believe that CRB checks and registration through the new Independent Safeguarding Authority should be done for all personal assistants, but the final decision for those with direct payments should rest with them.

Q370 Dr Naysmith: Is it not a bit patronising not to treat service users as grown-ups who can sort out these issues for themselves with support from advocacy and brokerage services as required?

Mr Low: I do not think so. If those services were provided through other more regulated providers those CRB checks and Independent Safeguarding Authority registration and checks would have to be done. For us it is a level playing field. It is part of a local authority’s public duty of care to make sure that they are done and the best possible information is put before the service user. Where disputes about personal assistants have arisen and cases have gone to the Local Government Ombudsman, the Local Government Ombudsman takes a very dim view of a local authority that is hands-off in this regard. There is a duty of care with the local authority and ultimately it is public money too.

Q371 Dr Naysmith: Lady Young, do you agree with Mr Low on this?

Lady Young: We certainly would expect local authorities to be able to assure us as part of our inspection of them in terms of their commissioning role that they have adequate mechanisms in place for safeguarding right across the spectrum of their activities. There needs to be a degree of flexibility as far as the personal assistants are concerned because many service users tell us they do not want regulation to intervene in the relationship between them and their personal assistant, they want to be able to make choices and if they choose not to take a CRB check they want to be free to do that. The important thing is service users have got access to support for taking checks on qualifications and proof of identity and CRB checks if that is what they want. If they choose not to want those, they have got to have the freedom to do so otherwise it gets in the way of the real flexibility that personalisation can mean for some people where they choose very informal sets of services to give them personal assistant support.

Q372 Sandra Gidley: A question to Mr Low. The Government would say that personalisation means a new role for social workers providing information, brokerage and advocacy, helping service users to put together their own care packages. Some would say that is a return to a “traditional” model of social work, instead of just “gatekeeping” the ready-made care packages. How do your members see it?

Mr Low: They do see the potential for the personalisation agenda to be more satisfying than being a gatekeeper but, unfortunately,
many employers—councils—are predicating personalisation on creating efficiency savings. The assessment process is time consuming to do well and promptly.

Q373 Sandra Gidley: Sorry, you said personalisation is going hand-in-hand with efficiency savings and that is not the case in my local council, they are very keen to say that it might cost them more money. What evidence do you have to say this is a cost-cutting measure?

Mr Low: Our surveys of the sheer caseload of our adult social workers show that they are experiencing the same sort of caseload they have got to work through as the children’s social workers were at the time of the Baby P incident. Quite frankly, their workloads are extremely large. Although a council might be saying personalisation can involve more staff time, the point is it is a workload issue. Secondly, some councils are deciding to slightly re-profile the assessment process and often it is not professional social workers doing the assessment but support staff, care managers and others. Some of them are using the personalisation process to re-profile where work is done in social services teams.

Q374 Sandra Gidley: Is that not the same as skill mix in the Health Service? Is that not a good thing?

Mr Low: In the Health Service and education, yes, we are aware that support staff are taking on more roles. In the NHS it is healthcare assistants and in schools it is teaching assistants. It is a trade union question that goes back centuries, is it the rate for the job? We negotiate re-profiling of work all the time, it is our bread and butter.

Q375 Sandra Gidley: You mentioned Baby P and I think a few months ago UNISON warned about the possibility of a Granny P tragedy in adult social care. What evidence do you have for coming out with that remark?

Mr Low: As I said earlier, our surveys of adult social workers produced remarkably similar results to our surveys of children’s social workers in the size of their caseloads and the pressures upon them. Many find themselves doing their paperwork for court at weekends and evenings. With the rationing of care there are possibly many vulnerable adults who could slip through the net who do not get the number of home visits that they should.

Q376 Sandra Gidley: Baby P had plenty of home visits.

Mr Low: The situation there was also a multi-agency one. Often the social workers are telling us their caseloads are still incredibly large and that 70% or 80% of their time can be taken up on paperwork as well. I know the Social Work Commission, under Moira Gibb, is looking at ways to reduce bureaucracy and improve the IT systems that are often the bane of social workers' lives.

Q377 Sandra Gidley: Is what is needed to prevent such a tragedy, smaller workloads and better IT?

Mr Low: Smaller workloads is key and, yes, more streamlined administration and IT would go a long way to improving outcomes.

Chairman: Could I thank all three of you very much indeed for coming along this morning and helping us with this inquiry.

Witnesses: Ms Lin Hinnigan, Director of Strategy, General Social Care Council; Mr Allan Bowman, Chair, Social Care Institute for Excellence; and Ms Andrea Rowe, Chief Executive, Skills for Care, gave evidence.

Q378 Chairman: Good morning. Could I thank you for coming along and helping us today with our third evidence session in relation to our inquiry into social care. I wonder if, for the record, I could ask you to introduce yourselves and the current positions that you hold.

Ms Hinnigan: Lin Hinnigan, I am Director of Strategy for the General Social Care Council.

Mr Bowman: Allan Bowman, Chair of the Social Care Institute for Excellence, generally known as SCIE.

Ms Rowe: I am Andrea Rowe and I am Chief Executive of Skills for Care.

Ms Rowe: I will start. When I took up the job 10 years ago at the National Training Organisation, which was a predecessor of the Sector Skills Council, there was 80% of the workforce in social care that had no qualification related to their job role. We have turned that reasonably around so that now 60% of the workforce has got a qualification that fits their job role, which is largely the Level 2 National Vocational Qualification. Also, because right from the beginning the organisation recognised that the major budget for workforce development was going to be at a regional level we decided that we would have a fairly extensive regional structure, which was quite expensive but it certainly paid off because we have matched the funding that the Department of Health put in, which has been £15 million a year for the last five years, and have pulled into the sector over the last four years £73.8 million. Train to Gain and European Social Fund and Regional Development Funds have put in a further £133 million. We know that without our brokerage, without Skills for Care’s intervention, we would not have been able to get that. That has been the source of the funding that has raised the qualification of the workforce.

Q379 Chairman: I have got a question for all of you. We have heard from the previous witnesses about poor quality care. Can you each tell us briefly about your organisation, what it has done to improve the quality of social care and how far your organisation is to blame for the persistence of poor quality services? I know that end part is a bit tough, but I wonder who would like to start?
Q380 Chairman: In turn, do you think that has improved the quality of care?

Ms Rowe: It is very difficult. Qualifications are a proxy for skills really. There is a lot of research that says the more employers invest in their workforce development then the likelihood is their services are better. You have only to look at high achieving businesses in other sectors, private business, they invest in the qualifications of their workforce and deliver very good services if you think of Marks & Spencer, John Lewis, big companies like that. There is a lot of research that is so. In terms of the contribution, David Behan once described social care as the desert. We knew very little about both the employers and workforce in social care, so we set out to improve that data. Because we are a Sector Skills Council we have responsibility for providing world-class information on the sector. We set up this database called the National Minimum Data Set for Social Care and we now have about 80% of the registered providers who are registered on our database and they have begun to register their individual staff on this database. Into the data warehouse we are also pulling all the other research that goes on that is funded by LSC and the Government so there is one place where you can look for the data on social care. That is still a work in progress, but I pride myself that it has not cost anywhere near the databases that there have been in health. It has not crashed. We are working with a very good provider in that and it is progressing very steadily. Where we have maybe not done as much as we could and that may lead to poor quality care is we have not been as strong, if you like, about a career framework. If you look across at health and their skills framework, it is very clear. It has always been difficult because of the opportunities to progress in social care and we know this has an impact on retention. Retention is a problem. The turnover in the sector is running at about 18.3% across the whole and that is very poor. We do know that not having a good career path is a problem. I think with personalisation that is going to become an even bigger problem because if the personal assistants do not have training then they are not going to be on any kind of framework and progress. That is going to be an issue in the future.

Mr Bowman: SCIE as an organisation, unlike many others, covers the whole of the UK and, uniquely, we are also a charity. I will not go into the technicalities of why we are a charity. We cover children and families as well as adults and in that sense we are quite uniquely placed to draw on sources of information from across the United Kingdom. Our main function is to identify what works, why it works and to translate that into the kind of successful guidance that people can put into practice and use across England, in particular, for what we are concerned with here. The issue for us is that we need to put that in a format that is readily accessible. In fact, last month we launched—we did not dare call it Sky TV for obvious reasons—Social Care TV, which is an online television channel, a different way of trying to get to a sector. We have got 35,000 employers of varying sizes and a workforce of about 1.5 million. We may have a more limited number of commissioners in local authorities than health but we need to get to all of these people in different formats that enable them to use what works. One of our big focuses is to ensure that when we say what works, it is what works for the people who use the services. We road test everything we recommend very carefully before we produce guidance. That focus on the views of users and carers in terms of the outcomes that they want very much guides the advice we give. When it comes to the issue of do we have any responsibility for poor social care, I think the challenge for us is to get out to that very diverse workforce. Our main focus is how can we get to those parts that we do not reach currently: do we need to change the way we provide the information; do we need to make it much more accessible. We go out and take a great deal of stock of what people say they need in terms of accessible information and are guided very much in that by a whole range of stakeholders, providers, users, carers and local authorities, and we work very closely with that range of people to try and produce for them something that is useful.

Q381 Chairman: And improve the quality of care?

Mr Bowman: And improve the quality of care. As you would know, in social care there is very often no one way of doing things, there are several ways. We want to encourage innovation. We help people assess the new ideas and approaches in terms of “Does this actually work?” As the Care Quality Commission is trying to do, we encourage people to take responsibility for what they are providing and help them assess and evaluate whether it is genuinely producing better outcomes.

Ms Hinnigan: The General Social Care Council was established in 2001 specifically to raise the quality of care through regulating the workforce. Currently we only register social workers, so it is only one part of the social care workforce, and we regulate their training. I think it is important to say that we are a young regulator and in the development of the profession as a regulated profession it is quite early years. In setting up the register it became an offence for you to hold yourself up as a social worker unless you were appropriately qualified and on our register. That meant we had to define the population and their requirements to get onto the register. Then we created the codes of practice for all social care workers which set out the standards of conduct expected from them, and we hold social workers to account on that. That is an important part of public confidence and raising quality. We regulate the training of social workers. Social work became an all-graduate entry qualification with the beginning of the new social work degree in 2003. Again, that has raised the bar for the quality of entrants and quality of training and has put it on a par with nursing and teaching, for instance. Social workers do an immensely difficult job in very demanding circumstances and many of them work to very high standards and help to keep individuals and their families safe. There is more to do and we have set out to the Social Work Taskforce ambitions where we can do more as a regulator and we intend to, both in terms of quality, the robustness of our regulation and...
inspection of initial training, and in terms of what we demand of social workers in their continuing professional development. I would describe as fairly embryonic the requirements at the moment that every three years social workers have to re-register and demonstrate that they have done a minimum of 15 days’—90 hours—continuing professional development. The requirements of that need to be more robust, we need to focus people much more on particular requirements and levels and standards. There is more that we can do and we propose that we should do in that respect. That is our major contribution to pushing up the skill level and quality of social workers. It is really important to recognise that when they complete their degree that is really only the beginning and as a professional you need to carry on learning and increasing your competence and adapting as new challenges come along, as indeed through the personalisation agenda social workers need to adapt to that and we need to keep them up-to-date and progress that.

Q382 Chairman: Last September the Government commissioned a “delivery chain review” of all three organisations that allegedly was going to be published in December of last year. We are now into November and it has not happened. What is your understanding of the situation and the reason for the delay? Lin, you mentioned the Social Work Task Force. Does that review fit in with the Social Work Task Force at all?

Ms Hinnigan: It is important to say that the social care landscape has changed considerably since we were established and, therefore, as GSCC we want to make sure that any review of the role of the different bodies and to see whether together we had the right sort of architecture to deliver Putting People First and, indeed, Building Brighter Futures on the children’s services side. Also I should say that we cover social workers in children’s services as well. We welcomed it. Our understanding is that the review was completed in terms of the review team having made their findings but, given the Social Work Task Force being established, it was right for Government to wait until the outcomes of the Social Work Task Force because that will define what is the task. I think that is going to lead to a radical reform of the social work profession and will define much more clearly what are the tasks of social workers, how should they be trained, supported, particularly what sort of role employers play in supporting social workers in order that they can deliver the agenda in Putting People First. It is right that we should wait for that outcome and look at the totality of the task and then say what bodies are needed in order to deliver that and support social workers in that role.

Mr Bowman: Certainly the arguments around the Social Work Task Force have been a good reason to delay, and look at things that are important. There is one other factor. Within the Green Paper there is a recommendation that there be an independent source of advice, hopefully it might well be from SCIE, in terms of adult social care. Things like that will impact on what the landscape will look like in the future, so it seemed sensible to look at all the likely directions and then to bring forward recommendations. On the Social Work Task Force we are looking at over 80,000 or 90,000 social workers and we have provided a great deal of information and advice about how social workers should do their jobs more effectively. Again, we would want to look at how we would play into that in terms of whatever recommendations may be made, perhaps in a National College for Social Work.

Ms Rowe: The Social Work Task Force is a very important body that we have contributed to. We have provided quite a lot of the regional planning around the post-qualifying social workers, so regional planning of numbers and working with the supply side. Also, we provide the National Occupational Standards that underpin social work. Within the Sector Skills Council we have got our partners in the three countries and the Children’s Workforce Development Council, so that is where we do the work that crosses all the different bodies. I suppose for us the review was more about us not being a Sector Skills Council, if you see what I mean. We have a whole life, which is the Sector Skills Council, which somehow seems to escape the Department of Health’s mind occasionally. We often have to tell the Department of Health what DBIS and DCSF are up to and link it into their strategy. The review has been difficult for us. We had work to do in promoting what we did at the beginning of this because we had been busy doing what we had been doing and not being outward facing so much, we had been getting on with the regions and doing the work, but suddenly the Department, I think, found out what we do and liked what they saw and that has caused them to think again. For us, one of the difficult things is the Skills Academy because having made a proposal to set up the Skills Academy within the SSC—twice—the stumbling block was that we could not get employer buy-in and could not use our DH funding as proxy.

Q383 Chairwoman: It is a little bit of a confusing picture. Do you think we have too many quangos? Let me just qualify that because this is not numerical. This is about whether or not the roles that there are that each of these institutions have get confused and if there is the potential for confusion about who is responsible for what it does not seem to me that is good for the workforce or anybody else for that matter. Do you think this is an issue?

Mr Bowman: When our organisations were established, and CSCI was one of the organisations established at the time, there was a real problem with the alphabet because a lot of them sounded too similar and that did not help anybody. Of course, no sooner was CSCI about to come into existence than its transformation to CQC was announced. What we
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have is a relatively new set of developments in social care that are long overdue. When our organisations were established that was a very welcome and very comprehensive strategy to shift social care into the forefront of provision and consideration. As with everything else, things evolve over time and the National Skills Academy is now part of the landscape but was not there when the review began. We are seeing things evolving and developing, but I do need to put it in something of a numerical context. I do not think we are over-provided with organisations in social care compared to health or education.

Q384 Chairman: Is there any overlap? That is what users are going to look at.
Mr Bowman: That is one of the things that this review, when it is eventually published, will help us clarify. It is quite a favourable review, having seen the draft, but inevitably with organisations there are functions that one may be doing that might be better done by another. We have to see that as a normal part of evolving. The issue is, however, are we able to work together effectively whatever we do. I would argue that we have worked effectively and we work now with CQC. We try to manage that landscape and the overlaps rather than get caught up in structural and boundary issues, and you can see the products of that in some of the things that have come forward. The Centre for Excellence now comes in children, for instance, I could have argued that should have come straight to me as SCIE but then we would not have had onboard a whole range of other organisations which made that a better set of structures. It is that capacity as a relatively large number of organisations to work together that overcomes the potential for confusion that could arise.

Q385 Chairman: I saw some nodding heads when you were saying that. Has anybody got anything to add to that specifically?
Ms Rowe: It is really important for employers to hide the wiring. They do get confused if you describe it all, particularly the SSC with six organisations. Effectively, for the employers in adult social care we are the SSC in England. That is what they know and that is all they need to know. Similarly, with our set-up we have got better at describing all the work that we are all doing and how it fits together in a whole, all the pieces of the jigsaw. We get onto platforms and we are always amazed at how much it does fit. I am with Alan in saying I really do not think with a workforce of over a million that we have got too many bodies.
Ms Hinnigan: I would absolutely endorse the fact that the partnership working across us is very strong and, therefore, while there may be some potential for duplication and overlap, we make it work. I think there is an issue about needing to clarify that particularly for the sector so they understand who they need to come to for what and where things come, but the quality of the work that we get out because we are engaged with numbers of stakeholders, not only our own bodies but other bodies, benefits from that. The Social Work Task Force is saying there is a gap in the bodies in terms of a gap for a body to be a strong voice for the profession and a champion of the workforce. We, as a regulator, are very clear that we are not a champion for the workforce. There is a really clear role for a regulator which is strongly focused on standards in practice and in training, and that must be separate from the voice for the workforce.

Q386 Dr Stoate: Lin, you did say that one of your tasks is to hold to account social workers and what they do, yet a report last week by the Council for Healthcare Regulatory Excellence found serious failings in management and in particular found that you had deliberately stalling investigations into social workers in order to save money. What are you doing to try and address that?
Ms Hinnigan: That is a report that we obviously take very, very seriously and take very seriously our role in respect of public protection. We began to identify the difficulties in our conduct operations when we brought in a new interim director of regulation last April. As we began to uncover those we drew them to the attention of the Department of Health and put in place a recovery plan that was there in its first form in July before CHRE even started. We very much welcomed that and, indeed, our Chair had invited the CHRE to come in and do that report. The things which they have recommended of us in terms of operational conduct matters are things that we already had in train and have made significant progress on. For instance, we have over 100 interim suspension orders where we believe that social workers may represent a risk to public protection and, therefore, they have been stopped from working. We have no cases unallocated as of the end of last week, although there may have been one or two that have come in since. We have revised our risk assessment framework. We have raised our threshold for risk assessment. All cases are risk assessed within 24 hours. If we believe there is a public protection issue those are referred to a committee for consideration of an interim suspension order within 48 hours. We have brought in external casework specialists, expertise, and brought onboard nearly 50 external investigators with investigatory skills, people like police officers, et cetera, who have experience investigation so that we can use them to help get rid of some of the older cases. All of the older cases pre-2008 will be dealt with by the end of March. We have that flexible resource now to enable us to do that. We are very confident that we are on top of the issue. There is a lot more work still to be done to make sure that the conduct operations are on a sustainable basis going forward and we need to revise the way in which we work. There are some recommendations that we welcome from the CHRE around changes to our powers, et cetera, but in terms of the immediate casework issues we are very much on top of those.
Q387 Dr Stoate: Obviously that is very reassuring indeed, but it does rather beg the question of how you could have let literally a backlog of, at one time, 700 unallocated cases build up that had not been dealt with, including a number of public protection cases. It does make me wonder how that situation could have arisen. I am very pleased with what you said about what is happening to put it right, but how did you get into that mess?

Ms Hinnigan: There were probably a number of factors, and I have to say neither the Chair nor the executive team have knowledge because we were not there at that time, so we are not able to explain exactly what happened. It was clear as we began to uncover the problem and it was clear from the CHRE report that a very significant factor was lack of appropriate, robust management information so we knew what was happening. We were getting certain indicators around certain aspects of the process reported but it was inadequately robust to enable us to properly manage the caseload.

Q388 Dr Stoate: We just have to hope that it has now been put right.

Ms Hinnigan: That has been put in place.

Q389 Dr Stoate: One of the recommendations in the report was that you should move to a system that effectively considered fitness to practise rather than conduct. How do you feel about that?

Ms Hinnigan: It is certainly something that we are keen to work with the Department of Health to explore. It will be a significant change in role because at the moment we look at conduct. To look at fitness to practise and competence implies quite a significant shift. We need to be very clear about what professional standards are at particular stages for particular roles. We need a lot more work, which we hope the Social Work Task Force will move us towards, around defining exactly what you should expect of a social worker in particular roles at particular stages of their career. The other thing we would need, and again this comes out from the CHRE report, is a wider range of sanctions. At the moment we are only able to remove somebody from the register or suspend them or give them an admonishment. In order to have an effect on competence we really need the ability to set conditions. In other words, “You may only work in a certain case. You must undertake certain additional training or whatever before you can be allowed to work in certain cases.” That enables us to lever up quality. We do not have those powers at the moment. There are a number of factors to be addressed and it is not a simple matter but something that we are positive about exploring with the Department.

Q390 Dr Stoate: It only brings you up to where the General Medical Council is, for example. They have been doing exactly that in terms of fitness to practise and conduct and making recommendations and sanctions, particularly around extra training and so on. There are plenty of examples of models out there.

Ms Hinnigan: There are models, particularly models for medical professions. A slight caveat is that many experts in the social care field would say that one has to be a little bit careful about translating medical models directly into social care, they may not be so easily transferable, and that is what we need to look at. In terms of setting standards for competence, that is something which we think would help to raise standards.

Ms Rowe: We should recognise that the domiciliary care sector and employers had got really fired up to register homecare staff. Although there was lots of debate about it, there was this energy there. I am anxious that we do not lose that and we work with the employers to see whether we could come up with some kind of recognition. I have held a long-term belief that, like the Health Service, we do not have the nursing profession that is like the mean running through the whole workforce and you identify the NHS in other nurses. Social workers have never been like that in the social care workforce, they have always been the elite doing something different from the social care workforce. Our mean is around Level 3 and Level 3 is mainly in the domiciliary sector. There is worth in exploring some kind of employer recognition because I think it would be a real shame if that workforce got the message they are not worth registering because of the difficulties that have happened. This would be a way of not pre-empting what the GSCC might do in the future around regulating it, but it would be a stepping stone and would not lose that energy.

Q391 Charlotte Atkins: Mr Bowman, what evidence do you have on how much personal budgets are now being used?

Mr Bowman: I have got some figures that were produced relatively recently. In March 2009 some 93,000 people in England were using services and 41% were older people. What that translated to across England was that was 8% across all local authorities with a wide variation from 1% through to 31%. There are some interesting developments. A recent survey carried out by ADASS said that they should achieve the Government’s target, which they agreed with ADASS, of 10% of people receiving personal budgets by March next year. They believe that puts them on target to meet the 30% April 2011 target. That is because by October all people are going to be offered a personal budget at the point of assessment. There is a fairly strong direction of travel established and with all the necessary pieces in place it does look as though the targets will be achieved. The issue with personalisation is do you have the infrastructure to support it, because we do not want simply to say; “Yes, we have met 30%” but 30% of what. You need to have the necessary support available in each community to enable people to access personal budgets and to use them well. Local authorities need to ensure the range of provision is there. There is no point having a budget if you cannot buy what you need. There is a whole range of activities that local authorities are engaged in. It is not just about meeting the target but
changing the way services are provided. As we heard earlier, that is against a background of threats and reductions to budgets.

Q392 Charlotte Atkins: Are there big variations between areas?
Mr Bowman: There are big variations between areas. These are being addressed particularly at regional level by the Department of Health, who have their own regional directorates, but also through ADASS where I think the directors have seconded one of their number to work in the Department with a view to achieving this transformation in a uniform way across the country. Drawing on the best practice where some people are doing it, you have to ask the question why their next-door neighbour cannot do it. When you come to our role in terms of dissemination, if we identify good practice in one authority then whether working at regional or national level we are endeavouring to help people do what is done elsewhere and to get the benefits that those authorities have been able to identify.

Q393 Charlotte Atkins: Is it possible to further break down those figures that you gave us and tell us what proportion of personal budgets are taken as cash direct payments?
Mr Bowman: I do not have that information in front of me. I imagine it would be possible. The point was made earlier that we need to be very careful about personal budgets. The fact that somebody gives you a pot of money and leaves you to get on with it is not the case. Some people want that and will be perfectly capable of getting on with it, but a lot of personal budgets are made up of a range of services that are administered by the local authority to meet an individual’s aspirations. It will be interesting to compare the elements because some of these will be part cash, part kind and others will be wholly cash and others wholly a range of different provision from different sources.

Q394 Dr Naysmith: Lin, if I could quote from your memorandum. You say that social workers’ skills and knowledge will fit them to “take on the new roles aimed at supporting people to design their own care packages” and supporting service users’ families. However, the Director of Community Services at Lancashire County Council has suggested that personalisation could mean service users being left to their own devices, sounding, as he says, “the death knell for social work”. How can you be confident that he is wrong and you are right?
Ms Hinnigan: Whatever changes may be going on locally, the vacancy rates do show overall there is 10.9% of all posts vacant, 13% in children’s and 12% in adults. The LGA released research this week around children’s services saying that 60% of councils are experiencing retention difficulties. The idea that there are too many social workers around does not seem to be borne out by the evidence. In terms of the skill sets, because of changes to the way in which social workers have worked some of them do feel they may have lost some skills in terms of they have been more in a rationing role. Again, I revert to my earlier theme around continuing professional development. We need to ensure that social workers are skilled up through their continuing professional development to develop the particular skills they need for personalisation. I think they are there in their basic core skill set but may well need refreshing because they have been using them in different roles recently.

Q395 Dr Naysmith: Do you think there are currently enough social workers with these skills who have been exercising them enough recently to be good at using them, or have we got too many of them? I suppose we could look at it the other way round as well.
Ms Hinnigan: Whatever changes may be going on, the vacancy rates do show overall there is 10.9% of all posts vacant, 13% in children’s and 12% in adults. The LGA released research this week around children’s services saying that 60% of councils are experiencing retention difficulties. The idea that there are too many social workers around does not seem to be borne out by the evidence. In terms of the skill sets, because of changes to the way in which social workers have worked some of them do feel they may have lost some skills in terms of they have been more in a rationing role. Again, I revert to my earlier theme around continuing professional development. We need to ensure that social workers are skilled up through their continuing professional development to develop the particular skills they need for personalisation. I think they are there in their basic core skill set but may well need refreshing because they have been using them in different roles recently.

Q396 Dr Naysmith: I think we heard from a witness either last week or the week before that she felt this would enable her to return to what she had been trained for as a social worker.
Ms Hinnigan: Absolutely.

Q397 Dr Naysmith: You would agree with that?
Ms Hinnigan: That is a very common message you get from social workers, that they see real opportunities to return to what brought them to social work around helping and empowering people to take control of their lives.

Ms Rowe: We are doing a piece of work with the Department of Health and the Association of Directors of Adult Social Services to define the roles and tasks which is due to report very shortly. In a
sense, this will take a leadership role through the project to bring those directors who are perhaps out of sync with that into the fold.

Q398 Sandra Gidley: This is to Alan Bowman. Your memorandum refers to “concerns about the wider consequences of expanding numbers and roles of personal assistants”, including “the emergence of unregulated ‘grey’ markets, the effects of migrant labour, quality assurance and employment and training conditions”. It would be helpful if you could elaborate on some of that.

Mr Bowman: I think some of the ground was covered in the earlier discussion with UNISON in particular. There is a real issue about the tension between people’s aspirations in terms of employing staff directly and the regulation they are safeguarding. As quoted, my predecessor, Baroness Campbell, is very strong on wanting to retain independence and choice. The issue is about informed choice. It is all very well employing someone with a criminal record but you need to know that they have it, you need to know what they have done, and you then need to make that decision yourself. We do have to respect the very strong wishes particularly of working age adults to be very firmly in control. They have often felt badly let down by publicly provided services before and feel if they relinquish that control and their own authority over it that somehow they will be at risk again. The local authority, as we have heard, has a responsibility; a duty of care, so it cannot simply run a free-for-all. My experience, and this applies in some ways to personal budgets, has been that if you simply hand people money the chances of that working are very, very limited. If you try and provide services on the basis of you know best then the chances of them being happy with these services are almost nil. There is something about bringing the skills and expertise of the professionals who assess the role of the social worker, the people who provide services, commission services, in partnership with those receiving them. If you begin to get that kind of co-production or co-working right then the issue about the risks of a potentially unregulated market will diminish. It is right to flag up there is that potential. As personalisation develops and goes on, we do not know what other forms of provision people might choose to access and how that might be provided. There is likely to be considerable interest in self-provision or self-help from a whole range of groups working as co-operatives, or whatever, and we need to be alive to the fact that these are good innovations and we need to help them manage the risks in these innovations because usually they are about people taking control of their own lives and getting a better deal than they had before.

Q399 Sandra Gidley: I do not quite understand where migrant labour comes into it though.

Mr Bowman: That has been an issue in certain parts of the country about the costs of employment. We do not know what skills or backgrounds people have. My own view would be that was a temporary phenomenon as particularly immigration from Eastern Europe reached quite a high level and people were coming forward to do jobs when others were not offering to do these jobs. My view would be that as we move through and mature, in a sense, in our relationships with migrant workers we can begin to look at opening that up, and there are particular opportunities being opened up to migrant workers to train in residential care, in supporting people as personal carers and domiciliary care, but we probably did not react collectively quickly enough to the issues and implications of that.

Ms Rowe: Can I just add that one tends to see personal budgets and direct payments as being a personal assistant and a service user, whereas the reality is it is a service user and quite a body of personal assistants through the night and working shifts. Employment issues are really key. The service user does need to be confident that they are acting as a good employer and even if they do not want to be seen as an employer they need to be able to manage that risk as well. Also, I do think that if service users invest in development, and I do think they intend to do this because many of them want their personal assistants to have development opportunities, it is how that happens that they find difficult and where they are going to get the funding from for doing that. At the moment they can get personal assistants quite easily, but I think that will change and it will be more difficult. A lot of the personal assistants now are trained and inducted into the social care sector by the local authorities but it will cease to be like that and that is going to store up problems for the future.

Q400 Sandra Gidley: That is probably a good point at which to tell us about your “New Types of Worker/New Types of Working” project and any other factors that are affecting the make-up of the social care workforce.

Ms Rowe: We have talked about the changing roles of social workers and the changing roles of care staff and personal assistants particularly. We have had our New Types of Worker project going for some time. We believe that role development actually takes place on the ground, it is not something imposed from above, the innovation and everything else happens where people are actually providing the services, and somehow we needed to capture what was going on to find out how the workforce was moving and how we needed to prepare particularly for young people to enter that workforce. We did fund a lot of projects and out of that we have come to about 14 new kinds of jobs. You might be interested in a couple of these as an illustration. There is a community support worker which merges some of the roles and duties of homemakers and support workers under supervision from a relevant clinician. The benefits of that are the delivery of holistic service, prevention of hospital admissions, cleaner career pathways and improved retention. Another is assisted technology support workers, which is a group of staff undertaking the assessment of people who use services to determine what types of telecare equipment would suit their needs. Staff skills identified include having an interest in technology, having research skills and being able to
market the service and train people in the use of the
equipment. There are samples of job descriptions and
a list of identified skills. There is quite a lot of
development going on. We have always done this in
partnership with Skills for Health and occasionally
we have done it with Skills for Justice and also with
housing because many of the roles are getting into
those areas. We have got an interactive website
where the various projects can communicate with
each other and talk about what they need to share.
We brought out the principles of workforce design
out of the learning from the projects we have funded.
There are seven principles for organisations, so if
they want to start trying to capture the new ways of
working and the new roles they have the checklist of
what they need to be aware of. The good news is
there is a lot of change going on and new roles being
established with different skill mixes. We are in the
process of setting up the Qualifications and Credit
Framework, which are the new qualifications, so we
are not going to be doing NVQs in social care much
longer. We do not think NVQs are fit for purpose for
the social care sector, as it is going to be, because they
are big qualifications. We used to call them “full fat”
NVQs, which was a bit sexy or something. The
NVQs are felt suitable for a static workforce: they
take a long time and are assessment heavy. We are
producing units of knowledge and skills and all the
sectors will be doing this, so it is going to be common
across the public and private sectors. We are going
to have a Sector Qualification Framework that will
have these units on it and it will be much simpler for
employers to mix the skills. If they are involved in
one of the new types of worker they will be able to
go to the Framework and pick a set of units. It is a
real pick and mix system. We are going to have lots
column units with health. We are doing this in
partnership with Health and with Children to try
get a really flexible Qualification Framework
that is capable of meeting that innovation and
enabling employers to have the latest information on
the qualifications they need.

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Q401 Sandra Gidley: I can see perhaps the need for
flexibility, but there are some significant tensions in
the system which Alan Bowman mentioned. Is there
not a danger that all of these changes are going to
make the whole thing messy, completely incoherent
and nobody will have a clue what is going on?

Mr Bowman: There is always that possibility with
any innovation. The issue is what do you do to make
sure that does not happen. If you take a word like
“personalisation”, what does it mean? It means
many different things to many different people. If
that is the underlying philosophy then we need to
translate that into something meaningful. Not that
we sell anything because everything we produce is
free, but our most popular publication has been the
Rough Guide to Personalisation which tries to
explain in very straightforward terms what this
means. We have produced a number of specific
tings for housing, for home carers. “This is what
personalisation means for you”, and for advocates
as well. We continue to produce information as
different groups of people need it. What we are
trying to do is to say that personalisation is about
ensuring that people get the kinds of services they
want and they remain in control over them. Some
things will have to change for us to reach that
outcome: “This is how you can change. This is what
you might do differently. These are the things that
work” and sometimes, increasingly, “Certain things
definitely do not work, so do not do them”. It is
through that kind of preparation with our colleague
organisations and working through in a way that
ensures all the actors in this have an understanding
that is shared because confusion comes when
perceptions are mixed. If someone receiving services
does not have the same perception about what the
outcome is intended to be as the person providing it
then you have got problems. That is very much
where we see our role, not just SCIE but collectively,
in trying to ensure that all the bits of the system have
a clear and shared perception about where we are
trying to get to and, through that, avoiding the
potential for confusion and disarray. I always
remember with the implementation of community
care there were two agendas at play. One was about
privatisation of a lot of public services and the other
was genuinely about trying to support people to
remain in the community, but the confusion between
these two conflicting policy objectives undermined
an awful lot of good work. We are now alive to the
potential, so we are trying to ensure collectively and
together with our colleagues in the Department of
Health that people get the outcome they want from
it.

Ms Rowe: There is a lot of simplification to be done
both in the qualification systems, career pathways,
and also the funding. There are huge numbers of
streams of funding and we need to help the different
departments in Government. If I use the example of
supply of new entrants, the young people into the
system, there are apprenticeships, CareFirst Careers
and the Society, Health and Development Diploma.
If you are a small employer you are lost, so we need
specialist brokers to help them through the system
and that is not right, is it?

Q402 Sandra Gidley: I am glad you continued
because I thought for a moment you were
advocating specialist brokers.

Ms Rowe: No, I am not in favour of that at all.

Q403 Sandra Gidley: It is simplicity?

Ms Rowe: It is simplicity, absolutely.

Q404 Sandra Gidley: Lin, does this give you a
problem?

Ms Hinnigan: It presents challenges for regulation
certainly. It is right that the workforce should be
flexible, that we should be having new roles emerging,
and we would not want to be ossifying the workforce
by setting out standards saying. “This is what we
expect of these roles” so the roles cannot change. It
does present challenges for regulation and that is a
large part of the reason for us looking again at the
models of regulation and thinking what are the right
ways. The sort of professional regulation model that
is suitable for a social worker who invests a long time
in long professional training is different from people in other sorts of roles where they may be changing, more flexible and need to use the QCF Framework that Andrea was talking about of pick and mix and change and add a skill here. That does present different regulatory challenges and it means we have got to look at the regulatory models that we use for those sorts of workers.

**Q405 Dr Taylor:** I am so glad Andrea mentioned simplification because I am getting more and more bogged down with this: 14 types of new workers, personal assistants are undefined, qualifications are undefined, training is undefined. Lin, in your evidence you said: “Recent research found that only 7% of direct payment recipients had paid for their personal assistants to have any form of training”. Where are we going? Is this just back of an envelope stuff? Has nobody thought it through? Who is going to pay for training? How is it going to be delivered? Or are these personal assistants just a good friend who has come off the street and said, “I’ll help you with this, that and the other”? Can somebody make sense of it for me?

**Ms Hinnigan:** As Andrea said, on training there are a lot of people at the moment moving into personal assistant roles having come from roles in which they were trained, so there has been a source of people, but as we move forward there needs to be something particular in the funding that looks at how do you make sure you have got the right skills. That research around the people who have paid for training did show that although there was overall support by people who employed personal assistants for them to be registered and regulated, 71% of them said they wanted to retain the possibility of employing somebody who was not registered if they made that choice. Predictably, a large number of those were people who were using friends, relatives or partners. Do you start to impose upon them, “Your partner must have this particular sort of training”? The person who is employing that person may say, “Their knowledge and their learning has been learning about my needs and me and how best to meet them”. They are very complex questions to try and set out what are the requirements. We need to unpack this, but we will need to move to certain standards and have the ability for people as part of their choice to say, “I don’t want to take those standards”. As Alan said, you can tell me I can get the CRB check, and that is great, but if I choose not to then that is my decision. The key theme of the personalisation agenda is balancing risk and choice, and there is always a pay-off. There is no absolute right place but we have to continue to do that balancing act.

**Q406 Dr Taylor:** So a personal assistant could be an existing carer or it could, in fact, be a partner or a spouse?

**Ms Hinnigan:** Yes.

**Q407 Dr Taylor:** Andrea, I think you said that Skills for Care are thinking of training and certainly taking people who have already been trained in other aspects?

**Ms Rowe:** Yes. We are emphasising getting young people very much.

**Q408 Dr Taylor:** Young people?

**Ms Rowe:** Young people because we are going to run out of the people we normally recruit from. We have got to get some young people in. We are taking advantage of the Government’s extra funding for apprenticeships and persuading employers that apprenticeships are good news. We are working with the Department of Health and the Department for Work and Pensions on the CareFirst Careers which are taking NEETs—people not in employment, education or training—into social care. For a long time we have felt they are a good source of people to work in social care. We have put a lot of emphasis on that. We have put a lot of emphasis on induction. Induction was the first thing that we did that was not government driven, it came from the employers who wanted a common induction standard. We have now got common induction standards across Health and Children. Going round now, employers tell me that the induction standards are the best thing. Because there is such a big turnover of staff, many of them just get through induction. It is based on a 12-week programme and has the basic skills you need to start with. Together with the common principles of self-care, which is the personalisation bit, that will form a good foundation and with the migrant workers that is what is being used as well. We have had to struggle hard to get that funded because it is not an NVQ so we could not get public funding for the induction. We have had to use the money that the DH has given us, part of the £15 million, to promote that.

**Q409 Dr Taylor:** Are you talking about apprentice personal assistants?

**Ms Rowe:** Yes, there will be apprenticeships.

**Q410 Dr Taylor:** Who is going to supervise them?

**Ms Rowe:** The provider of the apprenticeship scheme would do that.

**Q411 Dr Taylor:** Who would be the provider?

**Ms Rowe:** It might be a college or a consortium of employers and colleges.

**Dr Taylor:** That is helpful.

**Q412 Charlotte Atkins:** Lin, should there be regulation of personal assistants or not?

**Ms Hinnigan:** This is a really complex issue and you have heard already from the earlier witnesses that it is really difficult to balance. On the one hand we certainly need to provide the right level of public protection so that people who are being supported in their homes are given that assurance. The same research that I referred to earlier revealed that one in ten direct payment employers had experienced some form of abuse at the hands of their workers. There is a significant protection and risk issue there. At the same time, certainly I have heard service users talk very passionately about their independence and right to make decisions for themselves and not wanting the state to interfere in what is a very personal
relationship and to regulate personal assistants would interfere with that and would fetter their choice and independence.

Q413 Charlotte Atkins: You said in your evidence that if you wanted to extend registration it had to add value.  
Ms Hinnigan: Exactly.

Q414 Charlotte Atkins: What is your view? Will it add value? Who decides that? Clearly we have a large number of personal assistants being employed in various ways and it seems to be fairly chaotic at the moment.  
Ms Hinnigan: Our proposal is that we will contribute to this debate, with Government support and Government agreement, by launching consultation on this. Last November our Council agreed some proposals to do some more work, to build on the research that we have already done to get a better understanding of these very complex issues and about the different perspectives and to be able to weigh up the benefits. It must add benefit. It must be proportionate to the costs, to the burden and to the impact on employers of personal assistants. What we propose to do is some more work to develop a better understanding and then to put those questions out in quite an open way to a very genuine consultation to seek views from different stakeholders as to the right way to pick through what is a minefield in terms of strongly held views on both sides about regulation.

Q415 Charlotte Atkins: Does the GSCC still have its aspiration to regulate the entire social care workforce?  
Ms Hinnigan: That is still Government’s commitment and it is in our primary legislation that we should extend our regulation to the whole of the workforce. The work that we did back in 2006 identified that the greatest benefit was around homecare workers because of the vulnerable nature of people in their own homes and, therefore, that is where we have been focusing our effort. As things have changed we need to look again at the model of regulation. There were 250,000 homecare workers at the last figure and there were something like 5,000 registered with CSCI in 2008, registered homecare providers. It is a very fragmented employer base and regulation will have to have a key link through to employers because they are the people who capture and have contact with the workers. As we heard earlier, the 21% turnover rate of homecare workers makes it an incredibly difficult population to capture and regulate. We need to think about how we can do it in a way which is streamlined, simple and deals with those practical issues of the number of workers continually overturning. Do we do it on a voluntary or compulsory basis, and on what levels of training? Are we simply defining induction standards as the basic training or are we seeking to raise standards? Should we set higher qualification levels and have the regulatory burden on employers around that when they have got a vast turnover of workforce? We are back to looking at what is the right model with the Government. We still believe that the workforce should be regulated, but the model for doing so needs to be proportionate and practical.

Q416 Charlotte Atkins: The Council for Healthcare Regulatory Excellence came up with a recent report and they were suggesting other sorts of approaches in terms of statutory licensing schemes, employer-led approaches based on codes of conduct, and practice and induction standards. Is that a helpful approach or not?  
Ms Hinnigan: Those are some of the models. As I say, we need to explore alternative models and those are certainly ones that are worth exploring.

Q417 Charlotte Atkins: You have not got any preference at the moment?  
Ms Hinnigan: At the moment no because, along with the Department of Health, we need to do much more to understand what might be the best approach.

Q418 Dr Naysmith: Much of the last 20 minutes or so, maybe longer, has been spent talking about domiciliary care workers and personal assistants, but your prime task must be to be responsible for the quality of social work education. What preparations have you got to make to work in this new era of personalisation in terms of the statutory training of social workers?  
Ms Hinnigan: As I said at the beginning, the social work degree is relatively new. The overwhelming outcome of research into that is that it is fit for purpose and has had a beneficial effect on the workforce but we need to do more to develop that. We have put a series of proposals and a lot of work into the Social Work Task Force about how we take forward both the initial social work degree and subsequent training. Some actions we have already taken. A very significant part of the initial social work degree is 200 days, which is about half the time, is spent out on placement and we need to make those placements, which are really key to achieving skilled social workers, of more consistent quality. There is evidence that the quality of those placements is inconsistent. Along with colleagues we developed a tool, the Quality Assurance Practice Learning Tool, which can be used as a benchmark. That has already been rolled out and is being used by numbers of higher education institutes but it will become mandatory for degree courses from September.

Q419 Dr Naysmith: Is it mostly theoretical or are there some pilot schemes running on the changes you have just been talking about?  
Ms Hinnigan: We are also exploring how we can make our own inspection of HEIs more robust. At the moment we work on a model that was agreed with Government when we were introduced and which fits with the way in which higher education is regulated. It is largely a self-regulatory model and we come along and monitor their quality assurance. We think we need to be much more hands-on and robust in doing inspections, going out and sampling placements involving both employers, who are a key part of this, and service users. We do already involve
service users in our inspections, but much more of that, more intrusive inspection if you like, so that we get a real flavour of what is going on and whether or not the student social workers are getting placements that are appropriate that are giving them experience of personalisation, for instance, that is equipping them to fill these new roles for the future. The other area I would focus on particularly, as I have mentioned already, is that of continuing professional development. We have put forward as the Task Force that we should both require an element of the current 15 days to be in formal assessed training and the potential for that to be accredited courses that count towards your days and we should use that to direct some of the content. For instance, to direct that all social workers have an element around personalisation if that is what they wanted to do. Also, the evaluation of that in terms of its impact on employment should be built in, we should be able to demonstrate value for that. There is an upping our game in terms of what we demand both from initial and ongoing training that will ensure we continue to develop social workers so they are fitted for the personalisation agenda.

Q420 Dr Naysmith: Andrea, Skills for Care is responsible for the post-qualification training to a certain extent. What do you think of what has just been said?

Ms Rowe: It is shared. I just wanted to say one of the things that employers say about the social work degree is it is a case of one government policy being counterproductive to another government policy, so the policy to increase the numbers in universities to get a degree in social work is very attractive but I know employers say the social workers going in lack basic key skills.

Q421 Dr Naysmith: Are you talking about previous to this change?

Ms Rowe: It has not changed. The same evidence has come to the Social Work Task Force as previously that there are people going into work who do not know how to write reports and have those basic skills. Social care is always at the bottom end, just as in the whole workforce we always get the bottom strata of applicants because it is the lowest paid. If you have got a low status workforce then you get the poorest applicants. Sometimes that works to your advantage, as with the NEETs, because they understand the people they are working with, but not always. Employers really struggle. It is partly their fault because they have not worked with the universities strongly enough. Our contribution to the post-Task Force implementation would be to strengthen those partnerships between the employers and the providers.

Q422 Dr Naysmith: Is personalisation making any big difference to this?

Ms Rowe: As I say, I do not think that is necessarily the biggest issue. I do not think employers are saying the training is not fit for purpose in that sense. That is not what we are getting back.

Q423 Dr Naysmith: There has also been quite a lot of concentration recently because of the Baby Peter case on children’s services. Are we moving towards separate training for children and adult social workers?

Ms Rowe: It seems to have shifted away from that again. We always go into the reform of social work thinking it is going to split and it does not. The strongest advocates for keeping it joined up, of course, are Welsh, Scottish and Northern Ireland colleagues because they are in Europe and see social work as a European profession which is integrated.

Q424 Dr Naysmith: Why are they any more in Europe than we are?

Ms Rowe: They just are. They get more European funding than we do.

Q425 Chairman: I am watching what is happening in the Chamber and we are likely to have a vote soon. I have got a series of questions for Alan and what I am going to do is get through them as quickly as I can. Your memorandum says that research into “micromarket development” has shown “problems due to growing regulatory, legislative and other barriers and that the number of micro-providers is actually falling”. You say local authorities must address this “as shapers of local care and support markets”. Why is such a role needed, and is there any evidence that councils are up to the job?

Mr Bowman: The Audit Commission has been critical to some extent of councils’ capacity in this area. To put a very straightforward analogy: the local authority is the elected body responsible for the community that elected it and, whether it is a social care market or other forms of employment, part of its strategy has to be about saying, “What does our community need? How do we put in place all of the things that will make our community a good community with good quality of life?” To bring that back to social care, the local authority, with its partners in primary care trusts, in commissioning care services has got to think a bit more economically about “If we are going to invest, let’s not just get the cheapest bed per week. If we need a certain number of beds and you assume they have got some intelligence about the number of beds and projections, “what do we need to put in there to ensure there are sufficient numbers of beds, they are of high quality and have got properly trained staff”.

It invites a changed approach to commissioning services. You always use the old Marks & Spencer analogy. If they decide that you are going to be a Marks & Spencer provider they make sure you are a very good provider by investing in you, but they also set quality standards on what can be sold as a Marks & Spencer product. I do not want care reduced to Marks & Spencer goods, but some of the ways that economic markets are developed and shaped are what local authorities in some cases are very good at already through local strategic partnerships and other things. It is about helping local authorities to take not just that role in relation to the care market but, if you think about all the other things that we want, it is about free transport for older people
enabling them to get about and have a quality of life, it is about free swims because you do not have a local authority without public swimming baths. The issue is we want to have a healthy community and the local authority, as I do not need to tell you historically, was the big difference between poor health and ill-health at the turn of the last century. It is about looking at these things in the round and saying, “What are the things we need in our community that will give our citizens a good quality of life?” and then as they move with increasing needs, “How can we make sure in our community they will have the kinds of things that will give them that?” A lot of local authorities have demonstrated they are capable of doing that very well but what they need to do is translate that into the social care market.

Q426 Chairman: In relation to the evaluation of Individual Budgets that has taken place, 13 pilots, you say it “suggests that individual budgets have ‘the potential’ to be more cost effective” but “Reliable evidence on the long-term social care cost implications is not yet available”. Are we putting the cart before the horse by rushing into personalisation without even knowing whether it is cost-effective? Is it SCIE’s job to look at this?

Mr Bowman: Can I just say that we need to develop an economic model. There is no point in me saying this is the best way to provide care if I cannot tell you what it costs. You cannot make an informed choice as a user or a commissioner. SCIE is developing that economic role and it is one that we need to have, a bit like the National Institute for Clinical Excellence in relation to treatments and drugs. The issue on Individual Budgets is I think it has been wise to pilot them because the international evidence, while wholly positive, is not overwhelmingly positive in the sense you would say that we have got cast iron proof that this works. What we are seeing from the pilots are issues around younger people certainly, better outcomes, and potentially more cost-effective. For me, it seems we need to take the lessons from the pilot very carefully. The issue is once you begin to move from pilot to large-scale, how do you make sure there are no unintended consequences that would result in this system coming under pressure or simply not delivering. There we have to look at the views of older people in the pilots who, understandably, have often said, “I’d rather not have the hassle of managing a personal budget, I’d like somebody to manage it for me”. How do you introduce this concept in a way that improves outcomes? That brings us back to what investments the local authorities make. Are they going to have the support mechanisms there for people who have Individual Budgets? Are they going to have the provision there for people to spend these budgets? These are more critical points. I suspect from the limited evidence available that the biggest saver from Individual Budgets will be the National Health Service and that opens up the question of how do you then manage to transfer resources from health to local authority or health to social care.

Q427 Chairman: The Green Paper advocates “an independent body to provide advice on what works best in care and support” and to ensure that “services are as cost-effective as possible and that they are based on evidence . . . The independent body could be a new organisation, or we could give the remit to an existing organisation”. Does that have any implications for SCIE?

Mr Bowman: It does, and they actually mention SCIE as the kind of organisation they might use. The remit of this independent body fits very well with what we already do. We have the advantage of being a charity, so we are independent. As I said earlier, we do cover the UK, the whole spectrum of children, families and adults. We have a track record of producing reliable guidance research and knowledge. We are developing the economic model that I think has to go hand-in-hand with that because there is no point in just offering the advice on what is best if it is not what is best attached to “What can you afford and what are the likely outcomes”. I think we have established the kinds of partnerships and relationships across the sector, including with the National Institute, for instance, on the joint guidance on dementia which is applied across the whole health and social care sector. We have done other things with them on child health, foster care and so on. Our capacity to work collaboratively with others like NICE and, indeed, with our colleagues in the care sector would suggest that we are well-placed to be that independent body, and as an independent body to give advice that is not always that which would be sought but at least to be able to give that advice on the basis of rigorous research, rigorous road testing of what we do and rigorous evidence that this works or this does not work.

Q428 Chairman: I am going to tempt you to give some advice now you have said that. Alongside this emphasis on evidence-based services, we hear that people receiving direct payments will be able to spend their care budgets on all sorts of things that have not been rigorously evaluated as a cost-effective use of taxpayers’ money—from alternative medicine to football season tickets. Is this a contradiction in Government policy?

Mr Bowman: No, because Government policy is now focused very much on outcomes and if the outcome you want is someone to have a decent quality of life, to remain independent, to support themselves, then I think it invites a lot more imaginative spending of money than probably people like me would come up with immediately. We get the example quoted of season tickets and it is always the extreme. Of course, when you look into the particular examples that sound extreme and bizarre there is generally a very good, logical and sound reason for that and quite often a saving in terms of other services that might have been used. The key issue is does the individual believe that they are better because of this, do they believe they have got a better quality of life and, in a sense, is it cost-effective. You do not go away from, “Is this a good use of money in terms of what we are trying to
achieve by outcome?” Of course, your choice of football team may determine whether it is a good use of money!

Q429 Chairman: I would agree with you.
Mr Bowman: We have a range of examples at a smaller level, which I will not go into because of time, but little things can make a tremendous difference to some people’s functioning at very little cost.

Q430 Dr Taylor: Coming to the funding options, Mr Bowman you have given us some details about the future funding arrangements and I am giving you the challenge to summarise your evidence-based views on the advantages and disadvantages of each option in about one minute each.
Mr Bowman: I am going to do the classic here and say my organisation’s and my concern is not which is the best form of funding, it is what is the best form of care to provide with whichever form of funding is available, and that is our role and remit. I would be like any other human being. I might have a view about what I would like for myself in terms of cost of care, but we have got to be realistic and say the focus for us would be the development of a national care service and something that ensures you get the same deal whether you live in Northumberland, London or Cornwall, and how do we then help achieve that.

Q431 Dr Taylor: What about the differences with older and working age adults?
Mr Bowman: I think we are going to have to be very careful with that in the Green Paper. The first thing that was welcome was that it tried to address older people and those of working age, but there are clearly very significant differences. The big funding issue is clearly for older people. When we begin to look at people of working age we do need to look at the whole system in terms of what incentives are there to work and what disincentives, which is a separate debate. There is a whole range of issues that need to be addressed specifically in relation to people of working age. In some ways, once you have made your decision about the funding model for older people that may be more straightforward. If we try to have one simple unified system for both we will be in trouble.

Q432 Dr Taylor: Do any of the three options give you a better chance of this unified system?
Mr Bowman: The insurance model provides certainty, which is welcome for all, but it would need to be a compulsory insurance model because a voluntary one would be very unlikely to work effectively for either older or people of working age. To be frank, the issue of how you fund the care of adults draws on many other sources of funding for older people. You may end up potentially with a very good system predicated around adults but the risk would be do we get to another watershed of 65 and you enter a different system. Whatever we do, we need to make sure a transition from whatever system we develop for adults does not result in you being worse off as an older person simply because you are older. There are all these traps that have to be addressed in terms of bringing forward a White Paper.

Q433 Dr Naysmith: Mr Bowman, in your memorandum you talk home care solutions offering much more scope for co-production between relatives, neighbours and formal services. You also talk about the possibility of a no-claims bonus as an incentive to provide more informal care. I am interested in that word “co-production” because it is an unusual word to use in this context. We will leave that for the moment. What you are talking about there is dumping responsibility onto unpaid informal carers, are you not?
Mr Bowman: No, I am not. This is where I think the evidence shows that unpaid informal carers are very keen to do their bit by their family but they do not want to be abandoned. They are likely to do more when the necessary services are coming in from home care, and that can be something like meals on wheels. All of the evidence that we are getting, and some of it is international evidence, is that people are willing to do their bit but they want the state to do their bit as well. Co-production has got many meanings, it is a dangerous term, but essentially it is about working with people to make sure they get the service they want, but into that equation you have to bring the carers and the family and the informal carers. I do not like to use personal experience too much but a member of my family in Scotland is in exactly that situation and I can see the benefit that has come from the provision of good personal care by a local authority against the range of things other people are happy to do around her, which I think would have been jeopardised had that care not come from the local authority. It is about that balance. We must guard against anything that abandons informal carers or relatives.

Q434 Dr Naysmith: A few years ago in my constituency there was a chiropody service run out of the local health centre which said to elderly people who needed their toenails clipped, “Have you asked your neighbour first? Go and ask your neighbour and if your neighbour will not do it, come back and we will see what we can do”. Is there not a danger of moving into this kind of area?
Mr Bowman: That is a danger, but I come back to what I was saying earlier: if I were the local authority and the primary care trust I might invest in Age Concern’s chiropody and toenail cutting service and make it universally available for people who want to access it. That would probably be more cost-effective than having to use the NHS chiropody services, for instance.

Q435 Dr Naysmith: The very last question: is this not a way of overburdening already overburdened carers, asking them to do more?
Mr Bowman: That would be the unintended consequence. I come back to where I started a wee bit earlier. Most carers want to continue to provide
care, but they do not want to be left to do the whole job. You have to give carers quite a big say in helping people work out the best form of care packages and things they want. There are simple things like timing. You have got to take account of where the carer is and what they can do. This is where I come back to what is a very good job for a social worker with adults, to facilitate and organise that and help people achieve a package that satisfies them all and does not overburden anybody. **Chairman:** A simple thing like timing has worked wonderfully well for us. We have now got a page that the vote is imminent. Could I thank all three of you very much indeed for coming along and helping us with this inquiry. Thank you.
Thursday 19 November 2009

Members present
Mr Kevin Barron, in the Chair
Charlotte Atkins
Sandra Gidley
Dr Doug Naysmith
Mr Robert Sym
Dr Richard Taylor

Witnesses: Ms Sheila Scott OBE, Chief Executive, National Care Association, Mr Martin Green, Chief Executive, English Community Care Association, and Mr Colin Angel, Head of Policy and Communication, UK Homecare Association, gave evidence.

Q436 Chairman: Good morning and welcome to our fourth evidence session on our inquiry into social care. I wonder if I could ask you, for the record, to give us your name and the current positions you hold.

Mr Green: I am Martin Green and I am the Chief Executive of the English Community Care Association.

Ms Scott: I am Sheila Scott, Chief Executive of the National Care Association.

Mr Angel: I am Colin Angel, Head of Policy and Communication at the United Kingdom Homecare Association.

Q437 Chairman: Thank you and welcome. I have a question for all of you to start this session. Obviously, we have been hearing about projections of demand for social care in the future. What assumptions are you making about demand in the coming decades and what are you basing these assumptions on?

Mr Green: From my point of view, I think what we are basing our assumptions on are the assumptions that you are basing your position on, which was outlined in the Green Paper. Part of the problem about developing any assumptions is that there are great regional and local differences around how services are developed, so it is very difficult to come up with a national view other than the demographic issue, which will, obviously, produce more people needing care.

Ms Scott: Just to add to that, I think we are assuming that the estimates are an underestimate rather than an overestimate. My members primarily provide residential care and right now there are large waiting lists in some areas, so we have to get it right by area and region as well as nationally, and we think that the figures that we see, whether that is from the National Statistics Office or from the Government itself, are generally an underestimate, but that is a belief; it is not founded on fact.

Q438 Chairman: Colin, would you agree with that?

Mr Angel: I would not disagree with my colleagues. For the homecare sector, particularly, we expect a considerable increase in demand given recent policy announcements. The other thing, I guess, is our caution that the homecare sector is largely limited by the supply of recruits and surety of supply. Those are issues that are going to be concerns for us for some time over the next few years.

Q439 Chairman: We are going to go into some detail about that. We have heard of projections of future costs as well. What assumptions are you making about unit costs in the coming decades and what are you basing those assumptions on?

Mr Green: Again, I think it is very difficult. What we would like to see is an independent cost-of-care exercise used as the benchmark for defining costs. Unfortunately, what we have is a monopsony position in terms of the way in which the Commission has managed the market. The costs, as they stand at the moment, are very much costs defined by local authorities rather than costs that are real costs for services and there are issues around cross-subsidy in that.

Ms Scott: I think one of the key things that the public debate that is going on needs to look at is are we looking for providers to supply a five-star service to everybody, not just in the care that is delivered, but (for residential care) in the accommodation that is provided, or does the Government truly mean what it says about a National Care Service that will provide basic care? There is a huge difference. Providers are expected by the regulator to provide that five-star service across the board, but our members have to take into account not just what we aspire to, but what is the available cash, and the available cash at this time cannot provide that five-star accommodation as well as a five-star service.

Mr Angel: We certainly would agree with Martin’s point that the local authority is a local monopsony and has a critical impact on the costs and, indeed, what is paid for care at home. We just observe, with a couple of figures, that when councils provide a homecare service they are currently doing that at a gross average hourly rate of £22.30. The same figure for the independent sector is £12.30. So we are operating, we believe, in a situation where costs are at an absolute minimum and we do not think there is much to squeeze. However, we are facing a restriction in the next spending round which is going to leave local authorities even more cash constrained than they currently are.

Q440 Chairman: Certainly we think there is under funding of demand. We are not sure about costs—but from what Colin has just said, it is quite clear there could be pressure on costs—but there is a view that we are actually panicking unnecessarily in terms
of the future of social care. What do you think about that view? It is not one that I hold but it is one that has been put to us.

Mr Green: I think, in terms of the agenda around things like personalisation, the increase in expectations is quite significant. If you look at delivering bespoke personalised care services, they are very much more expensive than delivering baseline care services in a one-size-fits-all scenario. I do not believe that we are underestimating the issues for the future. I think there are issues about the numbers of people who will be coming through and needing care, but there are also issues about raising expectations but not having a clear narrative about how you are going to fund that rise in expectations, improvement in quality and more personalised care.

Ms Scott: I think the service can be supplied—I have no doubt about that—as long as we manage the workforce. The issue for us certainly is around the funding of those people unable to pay for themselves, and that is why I believe that this needs to be planned now. It is no good us letting it run another 20 years: some very difficult decisions have to be made about how that funding is going to happen and because of the increasing numbers that are going to need the service I think that the decisions need to be made right now.

Chairman: We are probably going to have a look in some detail at what those decisions are, but let me start with Doug.

Q441 Dr Naysmith: Sheila, you mentioned a moment or two ago about demand varying across the country. Do the costs of supplying the services you provide vary significantly across the country?

Ms Scott: No, surprisingly, I do not think they do. There are some variations, of course. For our members primarily in the private sector the biggest cost is the cost of the building and the land, and that can vary dramatically—so in London clearly that has an impact—but the regular costs, apart from London, are fairly static. The cost of the service varies.

Q442 Dr Naysmith: Why does it vary if the costs are much the same?

Ms Scott: Part of the reason it varies is that there are some areas of the country where almost all of the service is purchased by local authorities, and they may use their dominant position to force the costs down—so that is not a negotiated position by many providers, that is a fee level that is set by a local authority—whereas, particularly in the south, the percentage of people paying for their own care is remarkably high, and I would say that they are paying the real cost of care rather than that bulk purchasing price.

Q443 Dr Naysmith: Is there an element of cross-subsidy going on, do you think—people who are paying for their own care are paying more than they need to—to subsidise local authorities?

Ms Scott: I would absolutely say there is not.

Q444 Dr Naysmith: There is not.

Ms Scott: You would not be surprised to hear, I would say that there is not, but it is true that where there are people funded by local government and people funding themselves there is bound to be some of that, but we always say to our members: you must calculate what the real cost of care is—that is the cost you declare and that is the cost that you charge—and then your negotiations with local government are a separate matter.

Q445 Dr Naysmith: You said there is not much variation across the country. Do you agree with that, Martin and Colin? Is that your experience?

Mr Green: On cross-subsidy, I think I would divert slightly from where Sheila is, because I do think there is a bit of cross-subsidy, though, of course, it can be identified as for example people having larger rooms so they pay more for that service, et cetera, but if you have a situation where you are not getting the true cost of care, and it costs a certain amount to deliver on the level of care and the quality of care, the only way you can make it up is through some other source. So there is definitely an issue about how local authorities sometimes pay below the market rate.

Mr Angel: I would not say that the costs for us are similar. In the homecare sector the price of an hour of homecare can vary by about 25% between the regions, with the most expensive in London and the South East at between £13.50 and £14.00 an hour and, say, the East Midlands and the North West at £10.50 to £11.00. That is largely made up, because the homecare service does not have property to be concerned about, by weekly wage levels. Around the country you could have a care worker in the North East earning, say, £6.20 an hour, while one in London may earn about £7.00.

Q446 Dr Naysmith: What effect do you think this variation will have on the future funding of social care proposals? You are going to have to have something that reflects that, are you not?

Mr Green: Sheila mentioned the issue about some areas being heavily reliant on local authority funding. If, for example, I am the Chief Executive of a large corporate group and I have significant under funding in one area, I might decide that I am not going to develop new and innovative services in that region because they are not cost-effective to deliver. What it might do in the long-term is change the availability of some services. So this notion of having a service that meets individual need might be okay in some areas, but it might be skewing the market in others because of the funding position.

Ms Scott: Before 1992 we had London weighting. At that time I was a home owner in London. It was significantly more expensive and that was reflected, and I think that it may have to be taken into account—not just London, but maybe some of the Home Counties as well. Of course, self-funders allow you to do things like pay higher wage bills as well, but, I think, if it is to be a universal care balance—
Q447 Dr Naysmith: Let us have a look at another aspect. How reliant is the industry on migrant labour? There seems to be quite a concern that there is a lot of migrant labour. Why is this? First of all, do you think that it is really happening (and most people think it is) and why is it happening?

Mr Angel: Yes, we do. UKHCA gave evidence to the House of Lords two years ago and we found around 20% of the homecare workforce were migrant workers. This has been further confirmed by COMPAS; Oxford University found broadly similar findings. That figure increases significantly in London, where estimates are between 40%-60% (which is ours) and 60%-70% from COMPAS. It is clear that migrant workers are a vital part of our workforce and we would not function without those people’s work.

Q448 Dr Naysmith: Why is that?

Mr Angel: If you asked employers, I think they would say that they have difficulty both in finding people who are willing to work for the wages that employers can pay and finding those who have the correct skills and aptitudes from the local labour market—British nationals.

Q449 Dr Naysmith: You will be aware of the recent Oxfam report that suggested that one in five care workers are paid below the minimum wage and often have to work long hours.

Ms Scott: I have asked to see the evidence, and I have not seen the evidence yet. Our members, like every other employer, are subject to visits by all sorts of people checking on those sorts of things, and prosecutions happen if that is the case. I certainly have not heard of any of our members. I have heard of our members having inspections on all manner of things.

Q450 Dr Naysmith: Are you suggesting it might happen outside of your membership then?

Ms Scott: No. I cannot say for sure, but I was really surprised by Oxfam’s position. They have never come back to us about the evidence that they have. I think the issue of migrant workers is really critical for us. It is COMPAS who we have worked with, as Colin has. Their report said that up to 60% of all social care staff in London are migrant workers. That is enormously high—much higher than I thought. Of course, we are seeing a shift now because of the financial position. There has been a slight shift and we have been employing more local staff than before, but it is a huge challenge for us because we need more and more staff. The homecare sector, residential sector, the needs of the people we care for are higher and higher, so we need more staff, and it is difficult, particularly in good economic times, to recruit when for so many employers the wages are not the best. However, we have other reasons that people might seek employment with us. There is the flexibility of hours, we are able to offer part-time work, we need to look at other added value that we can offer around training so people that might be unskilled finish up as qualified people, but it is never easy during economic good times to recruit staff to social care because of the current situation around wages.

Q451 Dr Naysmith: You mentioned earlier about low prices, suggesting that in some places you were squeezed by local authorities, and so on?

Ms Scott: Yes.

Q452 Dr Naysmith: Are homes closing because of these low prices or not being able to get an adequate return?

Ms Scott: We have continually over the last maybe ten years seen a shift from the small providers that I represent (and that is small and medium sized; I do not just represent small providers) towards much larger organisations. I truly believe that a wide diversity of provision and choice is the best and, sadly, that the smaller unit, which suits some people, is disappearing, and so, although I think the number of beds is not going down as much as one might have thought, the places where the care is being provided are certainly changing.

Q453 Dr Naysmith: Martin, you have not had a chance to tell us what you think about migrant labour.

Mr Green: Linking to that point, of course, I think it is really important that we do maintain diversity because of the personalisation agenda, and the more we have to deliver personalised care services the more we need diversity in the sector so that it can respond to individual need. I really reiterate all the points that my colleagues have said about the issues around the importance of migrant workers and some of the reasons why migrant workers are attracted and available to our sector. The Work Force Strategy that the Department of Health has looks at where we position this as a profession, rather than just as a job, but, partly, it is not backed by any appropriate response in terms of how we resource that. For example, if we did go to a proper, independent cost-of-care exercise we could then look at what it would cost to deliver that highly professional work force. I am not using the term “profession” in terms of saying people are not professional because they do incredibly complex and difficult jobs, but I do think we need to see the work force shift from being a paid-by-the-week, by-the-hour, by-the-session work force and delivering a career structure within it.

Q454 Dr Naysmith: Do you see any problems in the future for being so heavily reliant on migrant labour?

Mr Green: Yes, I think we are going to have problems in the future, particularly because of the new points-based system, which is going to stop people who have the requisite skills coming from non-EU countries. Part of the issue is about how we select our staff, and they need to be selected not only on the basis of their skills but also they need to be selected on the basis of things like attitude and core value. In terms of where the position around the EU staff is placed, it might be that there is this flood of people who could come in and do the jobs but the
question is: are they the right people and are they skilled enough and do they have the right attitude to deliver the outcomes we require; and that is, for me, a debate point.

Q455 Dr Naysmith: Finally, quickly, for all three of you: do you think there is any future in technological advances changing the need for reliance on migrant labour and making the whole system a bit more efficient, because you are very heavily reliant on labour wherever it comes from?

Mr Green: Yes, but I think we should remind ourselves that we are in a people business. People's quality of care can be added to and supported by things like technical support but, at the end of the day, I have never yet heard a person say that their quality of care is defined by whether or not the computer at the side of the room beeps: it is about the interaction they have with our colleagues and our staff. So I think we need to remind ourselves that quality in this sector is defined by personal care, and that is interactive care.

Q456 Dr Naysmith: You are not writing off technology.

Mr Green: No, no. I think it is very useful, and it should be, hopefully, the thing that allows us to have more staff time facing the service user so that the gains that can be made would, hopefully, deliver more quality interaction between staff and service user.

Mr Angel: In the homecare sector we do not anticipate that technology is going to make an enormous reduction in the amount of services used. For example, there will be some reduction in overnight care and perhaps a reduction in the number of very short pop-in type visits to just check on people's wellbeing. However, I think we would probably say that home care can be the response to telecare alerts where actually you need human intervention after the data has been generated.

Ms Scott: I think it has made a real difference already and I think that will continue. If I look now at the sort of people that are being cared for in residential care and in home care, their needs are much more complex and much higher than they were because technology is able to deal with some of the people that 20 years ago might even have been in a care home. I think technology has made a difference. I recently went and looked at some lifestyle homes where people will be able to live for a very long period of time before they might need to think about the next phase of their life. I think we will continue to see significant developments but, as Martin said, I am afraid it is never going to be able to replace (unless, I guess, it is some grand robot) that personal care that is so important to people.

Q457 Dr Taylor: Can we turn to the funding options. Briefly could each of you go through the three options and say which you prefer and your views of them?

Mr Green: What I would say is I did a lot of consultation exercises with users and they came up with a fourth option, which was about whether or not it should be funded by taxation; though, interestingly, it was not an option where they said we want people to pay more tax; it was an option where they wanted you to go back and reprioritise the budget and put social care higher up the agenda. So, I think, as I went out and about and I talked to people about the options in the Green Paper what people were saying was, I guess, people are confused as to why they think they should be paying for something that they consider they have paid for. That said, in terms of the options, I think my organisation's position is the co-payment option, of the three that are on the table, is probably the most sensible, as long as it gets real clarity as to how much the individual is expected to pay.

Ms Scott: We have worked with all sorts of organisations over the years. We have worked with insurance companies and others. We have seen so many schemes launched and fail; so I think the first thing that we think is that, whatever system is introduced, it will need to be compulsory. I am afraid it will need to be compulsory because, particularly for older people, social care is something that they never think they are going to need and we meet so many people who never expected to be in this position. We are with Martin. The co-payment system seems to us to be the fairest.

Mr Angel: At UK Homecare, representing providers, we did say that actually it was not really our job to have an opinion on the balance between the individual and the state, which was a good cop out!

Q458 Dr Taylor: You did go on in your paper to give us a lot of detail.

Mr Angel: We did. I think my summary would be that, like Martin, we are not keen on the three models proposed in the paper. I would certainly agree with Sheila that whatever method is chosen there needs to be an element of compulsion. Certainly, when we see eligibility criteria for homecare increasing, we do not see a similar increase in private purchase by those people who are no longer qualifying for state-assisted care and, indeed, I guess, our thinking just at the moment was that a tax-funded option or a more generous partnership model would be the route we go down.

Q459 Dr Taylor: What are your views about the recently announced policy about free personal care at home to individuals with high needs? What are your comments about that? No doubt you have seen the front page of The Times and the talk about Exocet missiles. Where do you come in on that idea?

Ms Scott: I thought we were in the middle of a public consultation about the whole issue, and so it was quite a shock, in the first instance, to have the announcement made. It is easy to understand, being fair, but one wonders where it leaves the other parts of the service. This is a large amount of money that has been dedicated, and we truly believed that we were having this major public consultation which would make these sorts of decisions. So this large amount money that is being allocated to one part of the service makes us think that other parts of the service may not be so fortunate.

Mr Green: There is another issue, which is how are you going to define this notion of people in critical need? If you look at local authorities, for example, the majority of them are giving services to people in
critical need. If you identify that as being the criteria that accesses this new approach to the funding of care, you would, in effect, have the majority of people who are currently paying something towards their social care being freely funded. I do not know whether there has been any analysis done of people who, for example, are paying for that through their own resources who might want to come forward—interestingly, there might be some people who are currently residing in residential care who would think to themselves, “If I can get that funded free in the community, I might buy a flat and go back into the community”—and whether or not that has been taken account of. In terms of the overall headline, which was about free personal care, I think we would be supportive of that, but I do think it seems a bit strange to have announced this in the middle of the consultation and, also, to have announced it at a time when there seems to be no coherent back story about how this is going to be funded, what the criteria are going to be; how it interfaces with other aspects of the health and social care system; whether or not, for example, the money that is allocated, as Sheila said, will be enough and, if it is not enough, what is going to be the price that is going to be paid in other parts of the health and social care budget—because it does not seem to be if you go over and above the amount that has been headlined as the amount extra—but if the cost is significantly more, it is the question of where that money comes from. So I think my view is it needs a lot of proper analysis before we get to a view on it.

Q460 Dr Taylor: Can I ask Colin if he agrees with the chap who fired the Exocet missile yesterday, who said that in Scotland the costs of care at home have gone up by 74%; that if you go over 30 hours of care per week at home it is much more expensive at home than in residential care? Do those sorts of figures add up?

Mr Angel: On the intensity of the service, yes. If services become very complex, often you need two care workers present at the same time and that, inevitably, doubles the cost of a standard hour of home care.

Q461 Dr Taylor: I am sorry to interrupt, but if you need two care workers at home all the time, seven days a week, how many staff?

Mr Angel: Not necessarily always at home at the same time, but when care is taking place, two people there.

Q462 Dr Taylor: How many people would you need to keep a rota with two available when needed throughout the week?

Mr Angel: That is too variable for me to be able to answer, I am afraid.

Q463 Dr Taylor: But you would agree that the costs of care at home over that sort of length of time are absolutely exorbitant?

Mr Angel: No, I would not agree with that.

Q464 Dr Taylor: I should not have put it in that way. It is more expensive than residential care for somebody with those care needs?

Mr Angel: That would depend very much on the prices in their local area.

Q465 Dr Taylor: There is a proposal to merge the Attendance Allowance budget into the social care funding stream. What do you think of that?

Mr Green: When I was involved in the consultations with a lot of older people and carers, this was a very contentious issue with them, and it was interesting. One lady said to me, if you look at the personalisation agenda, which is about putting power back in the hands of the service user, it was her view that probably the Attendance Allowance was the only particular bit of the benefit system that was doing that. She also raised a question, which was quite interesting, about the issue of the equalities agenda in relation to this. For example, were we having our conversation just after it had been announced that Disability Living Allowance was not going to be taken account of in this process, and she raised the question: why were people having this different view? She also raised the question as to why, for example, people who got child benefit were not being seen as that being taken into the whole of the education system. So it was about a conflict, in a sense, with Government policy to take it into the mainframe budget, but also very much a feeling that it was an equalities issue as well as an issue about care.

Ms Scott: I am absolutely opposed to any changes to Attendance Allowance. If it goes into the government pot it disappears, from my point of view. It comes out again, I am sure, but Attendance Allowance is targeted at individuals and it is not means-tested and, for the majority of the work that we do, for self-funders, it is the one piece of help that they get towards the cost of their care, and so to take it away, I think, would be very unfair, because it certainly would not come back to them.

Q466 Dr Taylor: That is very clear. It would just go into the local authority’s pot and that is the last that is seen of it.

Ms Scott: Yes.

Mr Angel: Yes, I would agree that the danger of it going into the local authority pot is very high. However, UKHCA—as we do not represent the views of people who use services—are very clearly here saying we do not have a formal view on this.

Q467 Charlotte Atkins: I would like to ask all of you, how should the different situations of older and working age adults be addressed by a new funding system? Obviously they have different needs. Do you think that the Green Paper properly addresses the different situations for working age and older adults?

Ms Scott: I think the Green Paper is focused on older people, but younger adults are mentioned. The needs of younger adults are quite different and, so I do not forget, I would like to say that younger adults with long-term conditions, when they get to pension age, it goes—the support that they get of any type, including funding, goes—and they become a retired person and they frequently have to move into another environment because the place where they have lived is much more expensive. It has always seemed to me to
be unfair that those people, often who lack mental capacity, their lives change so dramatically. I think we said in our evidence very briefly that social care for younger adults and social care for older people is so different. With younger adults, particularly with learning disabilities, one is trying to move them from dependency to independent living; whereas for older people their life is usually going in the opposite direction as they are likely to become more dependent. So I think it is difficult to combine the two in the Green Paper. I certainly think that at the moment younger adults are facing massive changes through local government about where they live, how they live, money that is available and it is more problematic for us. Our members may have supported them from very heavy dependency, but when they go out into independent living often the support and care that they need is not there and so their lives are not as good as they should be. I think there is probably room for a broader look at younger adults after this Green Paper is finished. I know that there are tans and director generals, but I think that we need to have a proper look. In the same way as we are looking at older people really with the Green Paper, I think that perhaps we need to look at young adults too to see what it is we aspire to, what we can afford and what the National Care Service could offer to them.

**Mr Green:** My view about that as well is that, if we are moving towards personalisation and if we are doing everything in an equality and human rights framework, what we should be doing is trying to define what the needs-based response is, so that we are not categorising people in terms of age groups but we are categorising people in terms of their need and how we respond to it. It is a moot point but, for example, an adult with a learning disability might have a significantly higher level of resource for their care compared to an older person with severe dementia but the need may be the same in terms of the amount of support required, and it will be very interesting to see how, when we get to an equalities framework, that is justifiable across the system. I think Sheila’s point, though, was very well made, that a lot of the changes that are happening to adult services are, in a way, catapulting some people into situations where they are not very well supported. Part of the problem is that a lot of the policy around particularly learning disabilities is predicated on people with lower level needs and not on people who have multiple needs. So a one-size-fits-all approach is being developed in the Department of Health which is very much saying no more residential care, and that is absolutely the right thing for others. People need to know that if their policy direction is developed on the basis of resource allocation needs—we all need to know that—but to have a debate and a discussion about personalisation, about choice, autonomy and independence on the one hand and then for people in the department to sit back and say, “You cannot have this, this or this service”, seems to me totally incompatible. So I just wish, on some of these issues, people would get their language in line with their policy.

**Q468 Charlotte Atkins:** Colin, do you want to come in?

**Mr Angel:** In the homecare sector by far our largest service user group is older people, so that balance does not seem too incorrect from our take on the Green Paper. I would certainly agree that younger disabled people generally get far greater funding, and that balance needs to be addressed in the debate following the Green Paper. I guess there is also the fact that younger disabled people generally have a greater appetite for directly employed personal assistants rather than services arranged by a homecare agency.

**Charlotte Atkins:** Thank you.

**Q469 Mr Sym:*** Martin and Sheila, why do you believe that hotel costs should not be part of a social care package?

**Ms Scott:** I think I was responding to that suggestion within the Green Paper. That was the suggestion within the Green Paper that the funding of residential care and nursing home care should be managed in the future. It is something that I and the National Care Association have thought about in the past, because this is an ongoing discussion/debate. I have always thought that people want to make a contribution. I do not think that they do not want to pay at all. I have always believed that they wanted to make a contribution. I think that they would think—this is just my opinion—their living costs they would be responsible for wherever they are. I do not think they expect the state to pay for everything. I think they expect the state to pay for what they see as part of the Health Service responsibility.

**Mr Green:** One of the reasons I think it is a good idea is it gives a bit more equity in the system. At the moment, for example, the like-for-like calculations that are done around whether or not somebody stays in the community or goes into residential care, if you stay in the community a lot of the costs inherent in you staying there are being met by the individual through housing or, indeed, by other government agencies. So if you then compare what people are paying for residential costs, people think that is very expensive. Well, it is partly because there are a whole raft of things incorporated in that costing model that are not incorporated in other costing models.

**Q470 Mr Sym:** What data do you have on the split between hotel costs and care and nursing costs? One of the things I noticed when I went round the homes in Poole was they all told me that the age profile was going up, so people spent more time in their homes, they came in several years later and, therefore, were frailer. So, apart from the split in costs, are nursing costs rising at a faster rate because of this, Martin?

**Mr Green:** Yes, the increased dependency is certainly having an impact, because people need far more support. For example, a lot of residential homes that were built 30 years ago have lots of car parking spaces outside because the older people who lived there were driving themselves there. If you look at the critical criteria now, nobody would get a publicly funded place unless they had not one but several conditions that meant they required ongoing support. So that is, obviously, going to be much more expensive. In terms
of where the split is, I think that is more difficult to quantify, and I certainly have not got figures around that, but if you develop an independent costs of care model, then you could clearly identify what the splits on accommodation were and have some kind of formula that would make it easy to do across the country.

Ms Scott: There is one expense above all others for care home providers, and that is the cost of the staff. It is between 55 and 70% of all expenditure. The majority of that will be care staff. If you think that is the majority of the expense then, on a very rough and ready basis, you would think that 60% of the costs might well be care because of the staffing element.

Q471 Mr Symes: Sheila, you say accommodation costs should be funded from the benefit system. Why and how should this work?

Ms Scott: I am sorry; I did not make myself clear. At the moment a significant amount of people are funded by the state for their social care. A chunk of those will be on benefits—older people with substantial benefits to support their state pension—and that was what I meant; that they should still be able to have those benefits to pay—I was just making the point—otherwise they might be left without a service. I think it goes without saying, but I just wanted to make it quite clear that there are a significant number of people who from their own income alone would not be able to afford to pay the hotel costs.

Q472 Dr Taylor: Coming back to the disparity in unit costs that we have touched on, we have been given figures from Laing and Buisson in 2007–08 about average unit costs for a place in a local authority care home: £716 per week compared to £420 per week in an independent sector home. Why is this? You have already mentioned bulk purchasing by local authorities commissioning very hard and driving costs down. Are there other reasons for this, or is that the reason?

Mr Green: Public sector pensions, enormous amounts of money spent in training, back office functions provided by local authorities that are part of the support to an in-house provision—so a lot of extra costs which are incurred because of the background support that people are given have been public sector rather than independent sector.

Q473 Dr Taylor: Are they paying their staff, did you say, £6.20 an hour to £7.00 an hour for care staff?

Mr Angel: That was the homecare sector.

Q474 Dr Taylor: What is the sort of average in the residential care homes?

Ms Scott: A similar amount for a basic care worker.

Q475 Dr Taylor: It is similar?

Ms Scott: Yes.

Q476 Dr Taylor: Would you agree that these wages are so low, in the words of one of the people at the seminar I went to yesterday, that to work in this you have either got to be altruistic or desperate for work?

Mr Green: I would say they are far too low. If we were benchmarked on a £720 per week income, we would be able to make them much better. There is a real issue about the way in which, for example, the structure of pay in the public sector and also the access to pensions and other benefits deter people from staying in the independent sector. Often people are entrants to the care service in the independent sector and then go on and get jobs in the public sector. So in order to get some kind of level playing field, we need to level up to where the costs of the public sector are.

Ms Scott: There is something else. A significant number of people that work in social care are women looking for flexible hours, often unskilled, and their education has not left them able to walk into an obvious career and, actually, social care does give them some significant opportunities because they are offered training. Training is available. They can go up the vocational route. It is possible to make a real career from an unskilled start. I am not saying this is perfect. It is work that is always available for people, but we still manage to get a significant workforce, and this is a workforce that we train. So there are some advantages for working in social care, and it is not always just the money, is it?

Q477 Dr Taylor: Absolutely not. These figures of £716 compared with £420: are self-funders paying nearer the £716 than the £420?

Ms Scott: Yes.

Q478 Dr Taylor: I think you mentioned, Sheila, if people want to buy an enhanced care service they should be allowed to do so. What is the role of these top-ups for enhanced care at the moment? How important is it for the businesses and the income?

Ms Scott: The statutory directive says that people should have choice, and the only criteria attached to that is around cost. So there will be some people who the local authority will fund, but their parent wants to go into a more expensive home and they pay the difference. That is one way. Many local authorities accept top-up, providing they can see what the extra service is. So it might be gold taps and a sea view. It might be that. It often is.

Q479 Dr Taylor: Better food; does that come into it?

Ms Scott: No, absolutely not. I think that is one of our big fears: that there would be this differential in service. Within a care home everybody would get that same service—the same food, the same
service—they would be paying for some sort of extras, or the cost of the service is that much extra where it is above the local authority limit.

Q480 Dr Taylor: As opposed to a sea view, it could be a single room rather than a shared room, those sorts of things?  
Ms Scott: Yes.

Q481 Dr Taylor: Sheila, I think you said you did not really think that self-funders subsidise the other people, and I think you, Martin, rather disagreed with that.  
Mr Green: Yes. I think, inevitably, there are differences in terms of where self-funders are positioned, as opposed to where local authority residents are positioned, because local authorities use their power to force down costs of care and, in some cases, do not pay the amounts that are required. If you look at that benchmark of £785, which is what they pay themselves, and then compare that to being in the community having to deliver care at £400, there is a great difference. Some of that difference will be about a whole raft of things that do not make an impact on the service, but some of the difference will be about service issues, and if the local authority is funding at a lower level, then there has got to be some way in order to fund the cost of a quality service.

Q482 Dr Taylor: One of the themes behind the National Care Service is fair funding and the national system. If it was a more universal funding system, would this reduce the need for cross-subsidisation?  
Mr Green: It would if it was based on a proper approach to having a costs of care exercise. My concern about this idea of a National Care Service is that nobody has yet told me how it is going to be delivered against the backdrop of having 350 local authorities, many of whom seem to be laws unto themselves, delivering what they think they will deliver without any clear justification as to why the difference. It is not even on the basis of a justify and explain policy. I was recently in Surrey, and they deliver different services to the people in Lambeth, for example, but when I tried to unpick with the chief executive and directors why that was, nobody seemed to know, other than to say, “This is the way we do it here.” So, if you get a National Care Service, there has to be a lot of structural work that lies behind it because one of the things that is unfortunate is that people in Parliament think an announcement is being delivered, and there is a lot of work between announcement and delivery, and if we are going to turn this from a promise to a reality there is a lot of work to be done and a lot of that is going to have to be structural, I am afraid.

Q483 Dr Taylor: Words to action!  
Mr Green: Absolutely.

Q484 Dr Taylor: A huge difference. Thank you very much.

Ms Scott: The key word, a word that recurs again and again in the Green Paper, is “basic”. This is a “basic” care service. I guess that those people with their own funds will still buy extra parts.

Q485 Sandra Gidley: A question to Sheila Scott. In your submission you say, “We are seeing NHS funding being denied more and more to patients, with many decisions blatantly ignoring national guidance about National Health Service responsibilities”, and yet Laing and Buisson’s report seems to indicate that there are now a lot more people receiving NHS funded continuing care. For example, in 2009 there were 47,000, compared to only 21,000 in 2005. What is your evidence for your rather sweeping statement?  
Ms Scott: We believe, there are some new criteria. We are seeing reassessments of people.

Q486 Sandra Gidley: I am sorry; you believe there are some new criteria. There were some national criteria introduced.  
Ms Scott: Yes, and we believe they have been amended.

Q487 Sandra Gidley: Are you saying those have been amended?  
Ms Scott: We think they may have been, yes.

Q488 Sandra Gidley: Surely we can check this. You do not know; you just think. Why do you think they have been amended?  
Ms Scott: My members on the ground understand there are new criteria. I have not seen that evidence. They understand there are new criteria. People are reassessed regularly under this system and, particularly in dementia care, if you have somebody with continuing health needs who goes into a dementia care nursing home there is some stability about the service: the same faces, people have usually come from the NHS. There is some improvement, but these are still people with very complex needs, but at reassessment my members (and it is not just in one area, it is certainly across the West Midlands and the East Midlands, but I am sure it is much wider than that) are finding some improvement in condition and, therefore, the award is being removed. Where does that money go?

Q489 Sandra Gidley: You are saying there is no incentive to do a good job?  
Ms Scott: Somebody actually said this to me: “This could be a disincentive to the unscrupulous.” That is not what is happening at the moment, but there is some concern, because, of course, if you have a healthcare award that is significantly more to provide the service than if you are providing social care to the same person, there is a difference yet the service has to remain the same. There is some genuine concern. Somebody I spoke to very briefly this morning said, “Where are those people to go
to?” They are going through appeal systems, et cetera, at the moment. No provider would like to ask somebody to leave, but if it becomes widespread then they may have to ask them to leave and their condition would then, of course, deteriorate again.

Q490 Sandra Gidley: So this is anecdotal evidence at the moment. You are not able to quantify it in any way.

Ms Scott: No, but I have an offer for you to go and visit one or two places where this is happening.

Q491 Sandra Gidley: But you are saying national guidance is being ignored. That is rather different to what you have just said. In your submission you say national guidance is being ignored at 2.22.

Ms Scott: Yes. That was a very sweeping statement, I think. I have got my evidence here somewhere.

Mr Green: There is also a general point about the interface between care services and health services. Lots of care homes, for example, are asked to pay for GP services, and this is something we have raised on numerous occasions.

Q492 Sandra Gidley: They are being asked to pay for GP services?

Mr Green: Yes. We have produced a report recently and several reports have identified this. If you consider that people in care homes are seen as being in the community and everybody is told that healthcare is free at the point of need, yet GPs are asking for sometimes very significant amounts.

Q493 Sandra Gidley: I do not doubt it.

Mr Green: For example, £69,000 was one case I saw. This also has a real knock-on effect in terms of how we are able to deliver to people with complex needs when we have not got the support of primary care. We have done some research where we have found there is a lot of this going on, but there is also a lot of ignorance within the PCTs that is going on.

Q494 Sandra Gidley: That seems to me to be clearly unacceptable. I wonder if Sheila wanted to come back on the decisions being blatantly ignored.

Ms Scott: I was just thinking how to put it because I have only just found the part in the evidence. We think that the welfare of people is being ignored for financial reasons. That is really where we are coming from. I may not have put it quite like that in the evidence that we supplied to you, but we do think that there is a financial issue here which is affecting the long-term welfare of people with what we believe to be continuing healthcare needs. The people that I am talking about (and, you are right, it is anecdotal) are extremely worried about what is happening. People are being reassessed after six months, which the people that I have been talking to think is quite early, and their actual healthcare of the person is not being taken into account. Of course people may improve with good quality care, but when that changes then everything can change. My members think that money is the lead on this rather than welfare of people.

Q495 Sandra Gidley: Okay. A question to Colin Angel. In the submission from your organisation you say that homecare workers are more and more taking on the responsibilities that were previously in the domain of district nurses. Could you explain or describe what evidence there is for that and, actually, if homecare workers can do it well, does it matter? Was it a bad use of the district nurses’ time in the past?

Mr Angel: I will consider your last question and respond at the end. I think it is quite clear, as a registered nurse qualifying 20 years ago although no longer practising, what homecare workers do now are activities that in my early days as qualified nurse would have certainly been left to nurses.

Q496 Sandra Gidley: Can you describe what those are, because I am not clear?

Mr Angel: Particularly medication administration. When I surveyed the homecare sector in 2008 I found 100% of providers are doing something connected with assisting users with their medicine and 48% of providers are doing what we would regard as full administration, which to my mind is a nursing responsibility.

Q497 Sandra Gidley: I thought that was not allowed.

Mr Angel: If we are talking about the same type of administration, there is no reservation on activities for registered nurses. So 50% were doing full administration. When I had asked that question two years previously, only 25% of providers said they were undertaking administration. We see a number of other activities, one of which is maintaining enteral feeding lines—that is supplying nutritional supplements through a tube into the gastrointestinal tract—frequent injection of insulin and managing pressure sores and wound dressings independently. What concerns me is actually that these roles are not necessarily requested by the purchaser and, unfortunately, we see district nurses handing over those activities because there is a care worker going into the home as well. That creates vulnerability for providers. They are taking on roles that their purchaser has not asked them to do, they are probably not getting paid for the time that is spent doing those activities and if they are that could actually reduce the time available for the activities that were actually commissioned. It is an uncomfortable situation for our members at present.

Q498 Sandra Gidley: Presumably the homecare workers are not being trained either in these roles; rather that it is an informal sort of training of variable quality. I would suspect.

Mr Angel: It is likely to be on-the-job training, it is likely to be observing practice on a number of occasions, having the theory explained and then having a period of supervision.

Sandra Gidley: Thank you.
Q499 Charlotte Atkins: Martin, you were saying earlier on that PCTs are often not aware of the activities of GPs in terms of charging care homes. What is your Association doing to alert PCTs of this practice when you come across it?

Mr Green: We have just done a report. We did a practice when you come across it? What is your Association doing to alert PCTs of this practice?

Q500 Charlotte Atkins: No responses from the chief executives of the PCTs.

Mr Green: I will not say we have had no responses, but we have not had action. For example, there seems to be no lever to say people in care homes should be able to access GP services and somebody in the Department of Health should have the capacity to say it is clear that everybody should have access to primary care services, if it is not happening, why it is not happening, and call somebody to account. Strategic health authorities, I would naturally assume, would have a role in that, and they have not responded either. So what we see in the system is some people do not know that it is going on, and that was quite shocking to me, that PCTs did not know that some of their GPs were charging, but when it is brought to their attention you get platitudinous responses of how terrible it is and little action systematically through the system to ensure that it does not happen again.

Q501 Charlotte Atkins: Can I suggest that you perhaps follow it up with a letter to the individual MPs covering those PCT areas.

Mr Green: Absolutely.

Q502 Charlotte Atkins: I would certainly welcome such a letter if it is happening in my patch.

Mr Green: Certainly. Of course, I also have followed it up by sending the reports to the Secretary of State, to the opposition spokesperson; so it is not as if politicians have not had these reports. The difficulty is that they seem to know there is a problem and they seem to agree that it should be dealt with. I do not know whether it is because there are no clear levers in the system that they can pull. I think, increasingly, what is becoming apparent is that a lot of the decentralisation which comes with the desire of putting things closer to people also has the effect, which is an unintended consequence, of taking away any capacity to deal with issues from the centre when you identify them.

Q503 Charlotte Atkins: With respect, it is all very well sending it to the Secretary of State and the Shadow Secretary, but I do think that where you have a local MP who has a relationship with the PCT and, presumably, also has a relationship with the care homes, that is where you are likely to get a better response. As I say, if there are any in my patch, I would like to know immediately, please.

Mr Green: It is a point well made and I will certainly follow that up.

Q504 Dr Taylor: Could we ask for a copy of that report to this Committee?

Mr Green: Yes.

Ms Scott: The letters are always very carefully worded, in my experience, and many small businesses just think this is something they have to pay. The letters are usually worded suggesting this is for extra services, and so many care homes, smaller cares home and, I suspect, larger ones too, just pay it. It is only if somebody contacts me, you, other people, that we say you do not have to pay, and you write back along these lines asking if they are paid for NHS?

Q505 Charlotte Atkins: GPs have had a significant pay hike in the last few years, and it seems to me that is something which they should be covering. Can I move on to something else now? Is personalisation a threat or an opportunity, in your view?

Mr Green: I think it is a tremendous opportunity. I think it will give us lots of particular opportunities to diversify. For example, the way in which things were commissioned was about commissioning block approaches to care. What we hope we will be able to do through personalisation is start developing innovative and creative new services; also to engage in discussion with users about, for example, some of the trade-offs that people might want to discuss. So I think it is a huge opportunity and as a sector I think we are ready to meet that challenge if we get supported through the commissioning process.

Ms Scott: It is an opportunity—I think the barrier for us is the regulator—if the regulator allows care providers to innovate, which is what we need to do. Sometimes the regulation itself has stopped that innovation in the past. I think we have a real opportunity now, with the regulator, to allow places like care homes to become real resources within the community—not just to be closed communities providing services, but to look out towards the community as well so that people might be able to come to care homes for other services. In a village a care home might be the store service as well as providing care.

Q506 Charlotte Atkins: So you think that personalisation and independent living can be made possible within residential care, not just within the home?

Ms Scott: Indeed. We would like to think that we have always provided a personalised service. This makes you rethink all of the services that you provide with such a focus on personalisation that we are encouraging members and non-members to rethink about the services they supply and also look at the way they are supplying those services, particularly around residential care. Because they have delivered services to a particular person for a long time that does not mean to say that they cannot
delve more and more into what that real person is to ensure that the services they are delivering are key, and that particularly is true for people with dementia. The best dementia carer knows as much as they can about the life of the person before and then you can really personalise a service for people. One of the keys is going to be able to find a large enough work force to deliver.

Q507 Charlotte Atkins: Colin, did you want to come in on that?  
Mr Angel: Yes. Personalisation clearly has to be an opportunity more than it is a threat delivering the most user centred services possible, doing those activities that are important to the individual receiving the care and greater job fulfilment for the homecare workforce. Yes, I recognise that pitch, that many providers realise that personalisation is what they have been doing all along or perhaps was what they were doing until local authority contracts became more prescriptive, and I do find myself saying personalisation is not the threat but the current purchaser of care services is. We have seen very little of the social care transformation grant going out to independent sector providers who deliver 80% of state funded care, very little explanation about what personalisation would look like as a service, and we have created some guidance for our members, for lack of anything else coming forth from the Department of Health, but we also see some quite strange and, we think, quite deliberate actions by councils in their current contracting business. The other day I saw a contract that, despite being a contract between the council and provider, tried to impose the contract terms on any self-directing service user that the agency provided care to, including somebody paying exclusively from their own funds. We have also seen contracts where the council has to give its express permission before a provider can deliver a service to a purchaser who has exercised choice and decided to head off—

Q508 Charlotte Atkins: We would certainly like to see some examples of that. If you could let us have that evidence, that would be very, very welcome indeed.  
Mr Angel: We certainly will do. Thank you for that.  
Chairman: I am conscious of the fact that in a minute’s time this session is nearly ended and we are about halfway through our questions at this stage, so I will ask for quick questioning and quick answers. You do not have to duplicate it if it has already been said.

Q509 Dr Taylor: I would like Colin to explain a little more. You say in your evidence you fear untrained, unqualified, unsupported and unregulated personal assistants. We heard last week the Care Quality Commission does not have any powers to regulate these privately provided personal assistants, so what regulatory changes are needed if we do not allow service users to make their own decisions?

Mr Angel: Could you repeat that last sentence?  
Q510 Dr Taylor: What regulatory changes do we need or should we just allow the service users complete freedom to choose their own personalised assistants with no regulation at all?  
Mr Angel: I do not have an intellectual problem with people choosing, making an informed decision not to undertake any checks on workers that they may employ directly. I do not follow the logic of a system that regulates the homecare sector considerably onerously but then allows a grey market of personal assistants with no checks being mandated whatsoever. So, yes, the change in legislation would be that unless you had a mitigating circumstance you would be required to check your workers before you employed them directly.

Q511 Mr Symes: How would you view the idea of council approved preferred providers for people using personal budgets?  
Mr Green: My view about that is it would be absolutely fine if I had any confidence that councils would not abuse their position on that, and that is going to be the issue. So I think my view about it is I would like to see councils out of the arena and the debate and discussion should be between the provider and the user, and that will be the way in which we would get to a much better position in terms of particularly the personalisation agenda.  
Mr Angel: We feel that many of the approved providers at the moment are actually closed to application, so that effectively they are a snapshot in time of those services that the council had checked out at the time immediately before the list closed, and often do not take into account new entrants to the sector or services that add to their quality or range of services. I do not actually think they are helpful.  
Ms Scott: Both PCTs and social services find it easier to deal with larger organisations. That does not necessarily fit in with the choice of individuals, and approved lists reduce the amount of choice that people have and also penalises, in some instances, small business.

Q512 Charlotte Atkins: Last week we had evidence from UNISON and they claimed that there is a lot of poor quality care. Would you accept that, and, if so, are your members at all responsible?  
Ms Scott: I have worked in social care now for almost 30 years and this has been a journey towards quality care. Not every provider is there yet, but I believe that we have seen a dramatic increase in quality care provided. We have such a robust regulatory system that that drive towards eliminating poor care must be continuing and, as providers and representatives of responsible care, we do not want to see poor quality care because it has an impact on all of us. I believe that the journey continues upwards. I do not think we are seeing an increase.
Q513 Charlotte Atkins: We are seeing a fairly dramatic staff turnover in social care, particularly in the private sector—not quite so much. I think, in the public sector—and that must have an impact on quality if you are getting this staff turnover, because you just cannot train the staff fast enough if it is going to be turning over. If that is happening, you accept that you are having excessive staff turnover, what is the best way of retaining staff: better salaries?

Mr Green: Yes. You talk about the fact that there is less turnover in the public sector. There are reasons for that, and they are down to some of the benefits and salaries. I agree with Sheila: I cannot sit here and say there is no poor quality care going on, of course there is not, but the reality is that we are on a journey. We are improving things all the time, but we are doing it against the backdrop of some of those real difficulties that you outline around, for example, the staff turnover and how that impacts on the quality of care.

Ms Scott: The recession has had an impact and increased stability levels.

Q514 Charlotte Atkins: Is increased salaries the way for you? You were suggesting that you have less high turnover in the public sector because of salaries and other benefits.

Mr Green: I think increased salaries is very much a part of it. There is also a bit about training, but when we talk about training I really wish we would stop throwing that out in terms of it being a tick in the box because for all this money spent on training nobody does very much analysis of how it impacts on the quality of the care. I also think there is a real issue about recruitment and getting people into the sector around their core values as well as around their skills. I think this is a sector where a lot of the people who work in it are very much driven by the values rather than the salaries, obviously, so I think there is a big job to be done to get all those things in line in ways that will help us to move to this being very much a career rather than a job.

Mr Angel: We had a very quick look at UNISON’s evidence yesterday. They did not present a picture that we recognise for the home care sector. I also looked at the quality ratings from the regulator of home care services yesterday, and if there is a difference, it is between local authorities having more ‘excellent’ rated providers than the independent and voluntary sector but both have almost identical numbers of ‘good’ services, which are by far the highest proportion of all ratings offered, so that changes the difference between ‘good’ and ‘excellent’.

Q515 Charlotte Atkins: What about ‘poor’ ratings?

Mr Angel: 0.3% of local authority services, of which there are far fewer than independent sector, and 1.1% of ‘poor’ services in the independent and voluntary sector. One does not feel happy about any poor grading but that is still a fraction of the entire supply.

Q516 Sandra Gidley: A question for Martin Green and Sheila Scott. There was an example of a care home whistleblower who wrote that in the care home where she worked they budgeted 70 pence a meal for each resident, the food was “mostly grey slops” and the staff had to “have a whip round to buy some decent food”. Could you tell me how much your staff members budget for meals?

Mr Green: I cannot. It varies.

Q517 Sandra Gidley: What would be the range?

Mr Green: I would not know.

Ms Scott: Two things. When I was a home owner I could not see the point of not feeding people, my customers properly. It just seems extraordinary to me that you would purposely do that. I do not ignore what the whistleblower said. Up to £5 per day, from the quick ring round that I did to be up-to-date, is what I think is the norm, and I tried to do a wide section of places. It is just extraordinary to me to think that would happen. I hope that that was an exception rather than a reality because the three high points in the life of a care home are mealtimes, so to think that you are eating porridge at every meal is just nonsense to me. Certainly when I was a home owner I treated those three points in the day as the key parts of each day.

Q518 Sandra Gidley: Is there not a danger that as the residents get a little older and frailer and probably less likely to complain that the standards could drop and cuts could be made?

Ms Scott: I truly believe that the NHS has a role to play in this in supporting care services on how to encourage people to eat techniques, et cetera, so that even if it is pureed it can be nicely presented and people can be helped as best as possible to eat a wide and varied diet.

Mr Green: There are some really good examples of good schemes within the sector. For example, the Anchor Trust has a catering scheme, Barchester have done a lot of work on for example the presentation of food and particularly for people who are very frail and have problems with appetite, et cetera, presentation and particularly portion size can be really important. I go out and about to care homes and one of the delights is that I go and I eat with the residents, so my experience is that things are good, but obviously that whistleblower’s experience was different and that is something that needs to be investigated.

Q519 Chairman: How widespread is the practice of local authorities operating “Dutch auction” e-tendering processes, and what impact does this have on the service quality?

Mr Green: It has been something which we have identified as being a real problem within the sector although of course we did identify it and we got some good support from people like Baroness Young, the Chairman of the Care Quality Commission, who condemned it, and likewise some people in local authorities and in the Department of Health. It seems to me absolutely outrageous that you would set the goal of delivering high quality care, go
through a tender process and then do a Dutch auction. I can understand why you might do that if you are buying a commodity like a pen for a local authority but certainly not in the arena of personalised care services. I think it sends all the wrong messages and it also will not deliver the right resources because if you tender for a service at a given level then that is the level that you expect and need to deliver that quality service.

Q520 Chairman: Does anybody disagree with that analysis?

Ms Scott: We just advise our members not to take part. There is absolutely no point because the next thing you know you will be exposed for providing a poor service.

Q521 Chairman: It is a common complaint that commissioners drive down costs while ignoring providers’ statutory and regulatory costs. We are expecting a new regulatory regime next year. Do you think that is going to change matters?

Ms Scott: It is going to make it worse.

Mr Green: My view about the new regulator is if what the regulator has talked about in terms of her desire to move towards outcome-based regulation, then I hope we will be supportive of that, and I hope that there is the support of the sector to deliver on the personalisation agenda particularly. The cost of regulation is always a contentious issue and it will be a particularly contentious issue in a situation where the cost of regulation will be the same but the engagement with the regulator might be far less, so some employers will raise questions as to why that is. I hope the arrival of a new regulator, particularly an integrated regulator, should be positive for the sector.

Ms Scott: I am extremely worried about the fees because previously Parliament set the regulator fee and now it is to be set by the regulator themselves, with no scrutiny, as far as I know, and that is why I am so concerned. We have seen their proposals about what fees they will charge to the Health Services and to hospitals and they seem quite high to me and so I am very worried about what is going to happen to social care as well.

Mr Angel: We, too, are considerably worried by the new regulator and the new regulatory regime. We do anticipate an increase in costs, not necessarily just the registration fees but the time and resources that are used during the inspection registration process. Looking at the draft guidance which has not yet been finally published, there is a much greater emphasis on the providers supplying self-assessment rather than an inspector visiting and forming the assessment themselves. The document that is about to be published is going to be far more generic than those the providers use at the moment. At the moment we have national minimum standards for home care. There will be one set of guidance for compliance between regulated health and social care services. We actually anticipate far more disputes between inspectors and providers. Because the requirements are so much more generic providers will have to convince their inspector that they are actually complying with the spirit of the requirement.

Q522 Dr Naysmith: Colin, can I ask you about your statement in your memorandum that local authority commissioners cut costs by only paying “for contact time—sometimes by the minute—or using short care episodes for 15 minutes”. How prevalent is this?

Mr Angel: Widespread. It is almost unheard of for a local authority to pay for anything but contact time, ie arrival at the user’s front door to departure. Of course in the home care sector there is travel time before and after each of those.

Q523 Dr Naysmith: What types of support are we talking about that can be provided in these sorts of minutes only episodes?

Mr Angel: Ideally they are really only suitable for the observation of physical safety, perhaps a very simple prompt, “It’s time to take your medication.” Unfortunately, what we are seeing are far more complex and intimate personal care tasks being shoehorned into smaller and smaller periods of time. That is very distressing for the person using the service and clearly not a satisfactory position for the care worker trying to deliver a very human service in a very rushed and limited time-frame.

Q524 Dr Naysmith: You say that is widespread?

Mr Angel: Yes.

Q525 Dr Naysmith: So what percentage of authorities would be using these short slots now, roughly?

Mr Angel: I do not have the data set but my response is I would be surprised if it was much less than 90%.

Q526 Dr Naysmith: Really? And what then are the real problems of this? You have outlined some of them but what would you say are the major problems associated with it?

Mr Angel: I think the ones I have outlined are the main ones. It is lack of dignity and the ability to perform tasks thoroughly rather than in a rushed manner.

Q527 Dr Naysmith: Presumably when people are whipping round doing five minutes here or 15 minutes there then it would be different people each time, or could be?

Mr Angel: Yes, that could happen. It does not necessarily follow directly that that is the case.

Mr Green: I think one of the other issues though is if you are there to try to enable and empower people, it can often take much longer, and if you have a very short time you might do things for people or to people rather than enable people to do things for themselves. In terms of the personalisation agenda we do need to remind ourselves that that is about empowering people to be as independent as possible not just doing things for them.
Q528 Charlotte Atkins: Last week we heard from Baroness Young of the Care Quality Commission that there is a definite “gradient” in quality of care between for-profit providers and others. We also see in the British Medical Journal that on average not-for-profit nursing homes deliver higher quality care than do for-profit nursing homes. How would you account for those findings?

Ms Scott: I do not read it a lot.

Q531 Charlotte Atkins: Colin, have you anything to add?

Mr Angel: I think that the point of return on capital invested is fundamental to the supply of independent sector services. They just will not be there if there is no return on investment. I have already alluded to the difference in the gross average hourly rate between what the independent sector receives and what the councils’ own services cost. I do not think there is an accusation that profit is squeezing quality down. I think the purchaser would be far more likely to be responsible for that.

Q532 Chairman: Martin, the latest Laing and Buisson report shows operating profits (earnings before interest, taxes, et cetera) in the corporate care sector ranging from 17% of revenue to 28%. How do you reconcile these levels of profit with your members’ pleas that they are underfunded?

Mr Green: Again, we have to go back to that issue about what the cost bases are within businesses and also the fact that we have a business model. I think also there are some issues where people are subsidising across the business, so, for example, some of these businesses are very complex and when you see the profit figure in the round there may be some businesses that are just very much at the margin in terms of the group profit position and other parts of the organisation might be turning in a higher profit. You need to unpick which elements were producing that level of profit. It may have been as well that some people had land acquisitions that they decided to divest themselves of in that particular year so they did not develop services. It may have been that they had put money aside to develop a particular service and because of the way in which the market went they did not use that in a particular given year. I think it is quite complicated. It is very seductive sometimes to pull out the headline and then say that means they must be making a lot out of this. Within that there are grades of different parts of the business that produce that profit.

Q533 Chairman: 17% is not a bad return on revenue, is it? I am not a businessman but is it a bad return on revenue, the lower end of these figures?

Mr Green: I think it is a pretty good return on revenue but the question is where does it come from and we would need to unpick that.

Q534 Mr Syms: How many care homes go out of business? Clearly some are profitable but there are examples in my constituency of a number which have had to close.

Mr Green: I cannot give you a figure I am afraid, I do not have that.

Q535 Mr Syms: But it does happen?

Mr Green: It does happen. One of the issues that needs to be taken account of is if we have this mixed economy of care as our position in terms of the policy context, one of the things that is a real issue is...
how the system prepares for a business failure. Particularly when we have seen what has been happening in the financial market, that is a probability at some point, or a possibility perhaps, and so we need to be really clear about how we deal with that if it happened.

Q536 Chairman: We know that private equity investors have taken over large parts of the care home sector. In 2007 the *Observer* said that for these investors “Granny is a profit centre” and in 2008 the *Evening Standard* said that they were concerned more about property values than “the ailments of the inhabitants”. Are those fair comments?  
Mr Green: No, I do not think they are and I would like to see them justify those comments. Of course, you could make those comments about anybody. You could say nursery operators are more interested in profit. You could say universities are more interested in their inward flow than they are in their students. It is very seductive to just pull out some self-opinionated view from a newspaper which is not backed up necessarily by any proper approach to defining where they came from other than the opinion of a journalist.
Dr Naysmith: It happens to us all the time!

Q537 Chairman: I would say you would get good agreement round this part of the table on that one. My last figure in this session is what profits do small providers make? Sheila?  
Ms Scott: I am glad you have asked me that. I reiterate what I said at the beginning that we should have this wide diversity of provision—public sector, voluntary sector, private sector, the large hotel-like provision and small provision. For the smaller business it is a lifestyle decision to have your own business, to invest in that business, to run it perhaps with your family, and so the profit that they are looking for is, yes, a comfortable income now, but the investment is the money they have invested into the business which they hope by the time they retire will give them a comfortable retirement, and so I think that small business does not necessarily look in that very business-like way of a yearly return on investment made. They are looking for a lifestyle as well as looking at it in the long term.

Q538 Chairman: Do we have a rate of return on small providers or not really?  
Ms Scott: No, but if I might I would write to you within the next couple of days and let you know.  
Chairman: Could I thank all three of you for coming along and helping us with this inquiry this morning. I am sorry we have overshot by a few minutes but thank you for a good session.

Witnesses: Mr Chris Horlick, Managing Director of Care, Partnership Life Assurance Company Ltd; and Mr William Laing, Economist, Laing and Buisson, gave evidence.

Q539 Chairman: Good morning. Could I thank you for coming along this morning to our fourth evidence session. I am sorry about the lateness of the hour but hopefully we can progress this session a little quicker so you will not miss lunch! For the record could you introduce yourselves and the current positions that you hold.  
Mr Horlick: My name is Chris Horlick and I am the Managing Director of Partnership Assurance Long-Term Care Division.  
Mr Laing: I am William Laing, Chief Executive of Laing and Buisson.

Q540 Chairman: Could I start off with a question to you, William. We have heard about projections for demand for social care in the future. As the leading market analyst what is your view on this, particularly on the likely future availability of high-quality social care supply?  
Mr Laing: We do our own calculations of future demand and we look up to 2080 and base them on official population projections. If you make the assumption that we are going to need the same level of care services on an age-specific basis as we receive now then the result of that calculation is that you will need more than three times the amount of care in real terms by the year 2080 as you need now. An awful lot of things could happen that mean that other things are not equal but those are the sort of numbers we have come up with.
primarily down to the regulations on pay, the minimum wage and conditions of employment like minimum holidays, but you would have to look forward and guess what any new Government would do in terms of those things.

**Q542 Chairman:** If we continue with current levels of funding, how far will the social care budget fall short of meeting the level of need, say in 20 years’ time?

**Mr Laing:** I have not done the figures on that, we have not done the calculations, but what I would say is clearly there is a requirement, bearing in mind what I just said about the demographic pressures that we are facing, for a lot more money in the system. Whether that comes from local authorities, the NHS or individuals themselves, there has clearly got to be a substantial increase in the amount of resources available.

**Q543 Chairman:** In our session last week we were trying to find out the margin of error that there is between demand and costs in terms of the models that people work on. Do you have any views about what the margin of error is for projections of both demand and costs?

**Mr Laing:** As I say, we have not made any attempt to project forward the amount of money that local authorities and the NHS is going to spend on elderly care. All we have done is to look at the demographic projections and based on that we know that there is going to be a substantial increase in need.

**Q544 Chairman:** What do you say to this view that we are panicking unnecessarily in this area?

**Mr Laing:** About the costs of care in the future?

**Q545 Chairman:** Yes and demand obviously?

**Mr Laing:** The basis of this is as follows: the bulk of spending on care services for older people at the moment is residential and nursing care. That may change in the future but at the moment that is the case. A substantial proportion of the significant proportion of the spending on care services comes from individuals themselves, people who fail means tests and pay for their own care services. If you look at what the balance is between publicly paid and privately paid care at the moment in residential homes, we see that the local authority paid proportion is going down slowly by about 2% or 3% a year whereas the privately paid proportion is going up. We could expect that to continue into the future. So that is going to mitigate the requirement for additional local authority resources. I am not going to say it is going to take it away entirely but it is going to mitigate it. The argument that this is sustainable in the future really rests on the fact that the way in which people fund long-term care out of their own pockets (and remember there is going to be a rising proportion) is through the sale of their owner-occupied property. We also know that the number of owner-occupiers is feeding through more and more to the very old population and therefore we can expect the number of people who can pay for themselves and who fail the means test to increase. I would say it is unsustainable into the future insofar as in each individual case the older person who has been admitted into a care home who has property will then be able to sell that property and therefore be able to fund long-term care. The amount of money you can get from the sale of a property is more than enough to pay for long-term care for life. In that sense the system is sustainable.

**Chairman:** We will pursue one or two of those areas in the next few minutes. Robert?

**Q546 Mr Syms:** A question to Mr Horlick: as a long-term care insurance provider, what projections are you making about future demand and costs? Do you agree with the Laing and Buisson analysis?

**Mr Horlick:** Broadly speaking we do, and I would echo what William has just said. We see an increasing demand; it is a fact, as William has just said, the local authority percentage is reducing and privately paid is increasing. I think the potential for the 20% of employed people to continue to fund the 80% of people who are not is slim, frankly. I am not sure it is a very electable proposition from your side of the fence and also the elderly are sitting on—estimates vary—over a trillion pounds worth of property assets and therefore it seems to be a reasonable assumption that they could fund their own care from that. Our particular point is that rather than it be a scandal that people have to sell their homes to fund their care, it is a scandal that having done so they should then run out of money. That seems to me to be the worst of all worlds and they then fall back on the state, which is totally unbudgeted for and unbudgetable for because the state does not actually know who these people are.

**Q547 Dr Taylor:** I really want to follow this up. In one of your reports you talk about the “calm before the storm” and you have said that owner-occupiers have so much money behind them, but looking further ahead we are now in the generation where people are having to leave university with huge debts, they are probably not going to be able to buy their own houses, so looking further ahead are we not in for an absolutely tremendous crisis when people no longer have property as an asset, and they have not been able to save for their own pensions? Are we not on the edge of an absolute time-bomb?

**Mr Laing:** When we were referring to the calm before the storm, what I was referring to was 2011–12 when local authority budgets are cut. That is bad news for demand and also for fees. Looking at the question which you put, which is a very interesting question about what is going to happen to our ability as a society to sustain this idea of a property-owning democracy, and will this not inevitably, because of the burdens that are placed on young, people mean a reduction in the number of people who are owner-occupiers, I cannot comment on that. I personally would have thought that the
desire to be an owner-occupier is so strong and the reasons for doing it are so strong that we will continue to have a very high proportion of people owning their own homes, but perhaps there are other people more expert than me to comment on that.

Q548 Dr Taylor: Maybe I am being unduly pessimistic on that.

Mr Laing: Maybe, maybe not.

Q549 Dr Taylor: To Mr Horlick: are you expecting more people to buy insurance products as a result of the public sector beginning to run out of money?

Mr Horlick: I think we are expecting more people to buy a particular type of insurance product. It is probably fair to say that there has been market failure in pre-funded long-term care. We are still providing that product and we are the only provider left in the market and it is safe to say that we do not sell very many of them. I think that is the reason that the voluntary insurance part of the Green Paper would fail because people do not volunteer to pre-fund long-term care. They assume they will never need it until they actually do. However, the immediate needs annuity product is one where you pay a single premium which guarantees for the rest of your life, however long that may be, to pay a particular amount of money directly to either the domiciliary provider or to the care home. In so doing, the person going into care can cap their liability. They may well have to sell their property in order to fund it but they can cap their liability. They are then able to deliver the residue of that funding to their estate. It is good for the care home because they have predictable, long-term guaranteed income and it is good for the local authority because they do not pick up the tab if a self-funder runs out of money.

Q550 Charlotte Atkins: Mr Laing, you wrote a book into 1993, I believe, Financing Long-Term Care: the crucial debate. Some 16 years later we are still discussing it. Are we just going round in circles? Why is that?

Mr Laing: We have not resolved the crucial question which was posed in that which is how far should the state take responsibility for paying for long-term care for people who have the means to pay for it themselves? To what extent should middle England receive subsidies in one way or another for the care services they may need to receive at the end of their lives? That debate has been going on and it has not been resolved in any sense by the Royal Commission or by the current proposals in the Green Paper.

Q551 Charlotte Atkins: So you do not think we are any further forward than we were in 1993?

Mr Laing: The one thing that has changed of course is that after the Royal Commission the Government did decide to make available free nursing care. Many people of course argued at the time that they should have gone further than that and made available free personal care, but that debate is still going on.

Q552 Sandra Gidley: Mr Laing, your report says the “Green Paper effectively . . . proposes that the funding of long-term care should carry on more or less as before on a means-tested basis with no more than cosmetic changes to the entitlements of property owners.” Could you explain how you arrived at that conclusion please?

Mr Laing: Yes, okay. Let us leave aside the new things in the Green Paper—the idea of a universal deferred payment mechanism, the national portable assessment of need and standardisation of home care charges—and just look at this key question of what sort of subsidy from the state should people with property assets receive. At the moment if a person has more than £23,000 of assets then they do not qualify for local authority support, therefore they pay for themselves. From the state they can receive free nursing care if they require nursing care. Also if they are in a care home they can receive Attendance Allowance. That Attendance Allowance amounts to about £70 a week or something like that. That is what you would get if you have assets over £23,000. The partnership proposal in the Green Paper suggests this: that every person, regardless of how many assets they have, should get something from the state in addition to the free nursing care. If you look at the details of the Green Paper, what it says in a paper which is referenced in a footnote is that they are making the assumption that residential care might cost about £500 a week. Of that £500 a week, according to this report that is referenced in the footnote, about £250 will be hotel costs and the remaining £250 is care. What the Government is saying is there should be a contribution towards care. The Green Paper goes on to say that this contribution should be between a quarter and a third of the care costs, so a quarter to a third of £250 is between £60 and £80. In another part of the Green Paper it says that we may wish to use the Attendance Allowance and to divert that into the so-called National Care Service. Attendance Allowance is equal to £70 a week so what in effect the proposal for partnership appears to be saying is we will take the Attendance Allowance of £70 a week and use that to pay the between £60 and £80 that they are promising to pay under the National Care Service. So I would say that is smoke and mirrors; no change at all!

Q553 Sandra Gidley: Thank you. That was very clearly put. You did mention the partnership model and we have heard from the King’s Fund, who originally sponsored the Wanless work, that the Green Paper lacks aspects of Wanless’s proposals, because I think Wanless was suggesting that there was matched funding. Do you think the Wanless option should have been up for debate too?

Mr Laing: Yes, I think it should. Wanless is more generous in terms of state funding. There the suggestion was that the state should be responsible for about two-thirds of the basic costs of care and then match pound for pound any spending of the individual. Obviously that is much more generous in terms of taxpayers’ money being used to subsidise individuals’ care. Yes, it should have been up for debate.
Q554 Charlotte Atkins: Your report says that funding reform could mean more care home residents being brought within the umbrella of inadequate council-set baseline fee rates. Can you explain why you think that is such a bad thing?

Mr Laing: It would be a bad thing for the care home sector in the sense that it is pretty widely recognised within the sector that local authority fees are much lower than individually paid, privately paid fees, and arguably are inadequate to incentivise care home operators to develop new capacity and to maintain existing capacity and good standards.

Q555 Dr Taylor: Mr Horlick, you have told us a bit about immediate needs annuities. I am not quite clear on your submission. Under point five “how do immediate needs annuities help?” the third bullet is 0–8%. Is that 0–8 or 0.8%?

Mr Horlick: It is 0% to 8%.

Q556 Dr Taylor: So it is quite a wide range?

Mr Horlick: It is. At the point at which you pay the single premium upfront, because either domiciliary care or residential or nursing care has an inflationary factor within it, you can choose as a customer to select the inflation that you add. You can either choose the Retail Price Index, which is fixed as of that year, or you can choose anywhere between 0% and 8%. What tends to happen is when a customer chooses one of those, the adviser that they buy the product through will agree with the care home that their fees will go up by no more than that, so that adds to the guarantee that for as long as they live they will have their fees settled.

Q557 Dr Taylor: If you die within six months you get your money back.

Mr Horlick: You do not get all of it back. If you die within the first month, you get all your money back. If you die in month two or three you get 50% back. If you die in month four, five or six you get 25% back.

Q558 Dr Taylor: So if you die at six months and a few days you do not get anything back?

Mr Horlick: No, there has to be a cut-off.

Q559 Dr Taylor: When you say “further additional capital protection can be purchased if required”?

Mr Horlick: You could then take out a separate insurance policy to protect the total cost of the annuity. Let us say you purchased an annuity for £80,000, then you could take out a life insurance policy that paid out £80,000 on your death. Clearly because you are an elderly person that is going to be relatively expensive but you can do it if you want to completely cover that cost.

Q560 Dr Taylor: And “relatively expensive”—what sort of sum are you talking about?

Mr Horlick: It is totally individually underwritten so it would depend on your circumstances.

Q561 Dr Taylor: Really to both of you, why has there been such a comprehensive market failure in social care insurance? Does it work any better in other countries?

Mr Horlick: I think the failure here has been in pre-funded long-term care. People simply do not perceive that they are going to have a need. At the point at which you are going to need to start saving, let us face it people do not save enough for their retirement generally so adding long-term care on top—

Q562 Dr Taylor: Everybody at the moment automatically assumes that they are going to be looked after?

Mr Horlick: The capacity in the system at present means that many people get to that point in their lives absolutely believing that the state will pay, and I think a degree of transparency would be very, very helpful to everyone who ends up in long-term care. On your second point, there are parts of the world where it does work. France has a much higher take-up of pre-funded long-term care. Part of that is because there is an element of compulsion in it. Singapore has a system, I cannot remember the name of but it is “Elder something”, which is also compulsory but they separate between two separate groups of lives, so the elderly already in care have one sort of approach and those who are coming up to that point have a slightly different approach but it is a compulsory system there.

Q563 Dr Taylor: How do you manage an “element” of compulsion; is compulsion either there or not?

Mr Horlick: In Singapore do you mean?

Q564 Dr Taylor: Here?

Mr Horlick: Under the French system?

Q565 Dr Taylor: Other witnesses have said there does have to be some form of compulsion here if we are going to go down this line.

Mr Horlick: Here?

Q566 Dr Taylor: Yes?

Mr Horlick: That is not the route we would propose.

Q567 Dr Taylor: How do you compel people to do this?

Mr Horlick: Option three of the Green Paper would compel people. It is not something that I think would be very popular.

Q568 Chairman: Is the French system in any way tied into how they pay for healthcare?

Mr Horlick: Yes it is. I do not have all the details. That is what I mean by there is an element of compulsion contained in there.
Mr Horlick: I think what is proposed here is a sort of fund management approach where everyone pays in a set amount, assuming we are going down the compulsory route, and they pay that in at let, us say, 65, and you hope that over a period of time by the time that proportion that need care go into care the funds have made enough money to pay for the demand. I think that is what is being proposed. It is not dissimilar, I have to say, to a home protection plan.

Mr Sym: Can the voluntary private insurance market ever grow significantly in parallel with a state-funded system?

Mr Horlick: Yes I think it can. Certainly if the partnership approach in the Green Paper was adopted, and I am not saying it should be or should not be, which is an entitlement for all, then clearly there is going to be a top-up required and, to a large extent, that is exactly what we do with immediate needs annuities now. Most people have some form of income. They may get some contribution from the state. The gap between what they are receiving and can afford to fund themselves and the total cost of their care is what we fund through an annuity.

Mr Sym: How difficult is it to predict long-term care costs for individuals? How serious is the risk of “adverse selection” (ie where the insurance is mainly being bought by those with the greatest need)?

Mr Horlick: In the market as it is now, immediate needs annuities are individually underwritten, so every single person who takes out one of these policies will supply us or Axa, the only other company who offer this, with a range of information. Typically, we will supplement that with a care management report, so a report from the care home and possibly a GP report, and issue them with an individual price, so the anti-selection point does not occur with immediate needs annuities because by definition they are going to claim on their insurance policy. The question is what is their longevity going to be and how good are we at predicting their longevity on a case-by-case basis so what is the mortality rate going to be for the book as a whole. Depending on how good your underwriting system is and how good your actuaries are will depend on whether you make any money out of it or not. The one thing that is clear is that the customers get their care fees paid.

Mr Sym: To Mr Horlick—the Green Paper talks about the possibility of a state-backed insurance to complement the state offer of support. In your view, how would such a system work in practice, if at all?

Mr Horlick: I think what is proposed there is not actually insurance. Insurance is where you pay a premium; the insurance company takes a risk, and they either get it right or they get it wrong. That is what an annuity is. I think what is proposed here is a sort of fund management approach where everyone pays in a set amount, assuming we are going down the compulsory route, and they pay that in at let, us say, 65, and you hope that over a period of time by the time that proportion that need care go into care the funds have made enough money to pay for the demand. I think that is what is being proposed. It is not dissimilar, I have to say, to a home protection plan.
Mr Horlick: In terms of market failure, my understanding of why Axa PPP, which was the leader in the provision of pre-funded long-term care insurance, left the market was simply because the risk was too high, because they had to predict not only what the price of care would be in 30 years’ time but also the propensity of their insured population to use care in 30 years’ time, and therefore they had to keep on putting their premiums up and it was not terribly satisfactory to their relationship with their customers. My understanding is that is why they opted out of that market. Other insurers may well feel the same, so in that sense the prospect of a state-sponsored insurance scheme does open up once again the possibility of there being products on the market to enable people voluntarily to pre-fund themselves. I think that is a genuine extension if this comes about.

Q578 Sandra Gidley: Thank you, Mr Horlick, what do insurance companies need from the state in order to grow a successful voluntary long-term care insurance market? Does there need to be any underwriting for example of the most catastrophic costs?

Mr Horlick: I suppose it depends what the background system is, but let us assume it is the status quo, what we have now, then because of the means test the most catastrophic cases are looked after and it is only self-funders and co-funders who end up falling on to the insurance solution. I think what is needed most is transparency. There is a real problem for self-funders and people who may have to fund part of it themselves because they simply do not know where to go. That is partly our fault and it is something I am trying to do something about, by promoting the availability of products such as immediate needs annuities. If you do go to the local authority and you are a self-funder and you fall above the means test threshold so you have to fund yourself, they actually, by and large, and probably in quite a nice way say, “Sorry, we can’t help you, goodbye.” Our contention is that it is at that point that the local authority should signpost these people to financial advice or advice of some sort which can help them through the system. There is a myriad of different websites, support lines, charities, all individually doing quite good jobs but none of them is really providing an holistic package that takes them through, “Right, those are your state benefits, make sure you are getting those. Which care homes have you seen? This is a three star, two star, one star, and all that sort of thing. Make sure, by the way, that they do the food you like or allow pets or whatever it is.” Then at the end: “And here is a selection of financial advisers who are properly qualified in this area to take you through how you can fund this.” Transparency would be the thing. I do not think there is a single body anywhere that brings that together. First Stop is trying but I do not think it is succeeding and local authorities certainly in the majority of cases do not address this problem at all for self-funders. Subsequently it comes round to bite them, which is the thrust of my submission.

Q579 Mr Syms: To both of you, the Conservative Party has proposed a privately provided voluntary insurance scheme to cover all residential care costs with a one-off lump sum premium at retirement of £8,000. Do you think that is workable? Why is it so much cheaper than other sums under discussion?

Mr Horlick: If I may! I have spoken to lots of people in the Conservative Party about this. I welcome the fact that it is a policy proposal and that it is being thought about and I welcome the fact that they anticipate private sector involvement in this. Other than that, I think there are some pretty flawed assumptions in it and the two most fundamental ones are the numbers of people going into care, so the front end bit of it, if you like, and at the other end their longevity in care. I have not seen the model so I do not understand the details of it but it seems to me to be flawed, I am afraid, and I have told Stephen O’Brien that on numerous occasions.

Mr Laing: I have nothing to add. I have not seen the details of it. It sounds a bit of a squeeze but I have not seen the details.

Mr Horlick: There are two other things that are not very clear. I do not know that they have taken into account any anti-selection effect, so they are assuming one in five need to go into care. That is already wrong. It is one in five men and three in ten women, and women form the majority of people in care. It does not take into account either any anti-selection effect whereby the people most likely to opt into this voluntary system are likely to be those most likely to need care, and so the one in five becomes even more of a problem.

Q580 Mr Syms: Is there some merit in thinking about financial products that combine pension insurance and long-term care insurance to try and combine the two?

Mr Laing: This was a live issue of debate a number of years ago when people were very flush with pensions and if you looked at what was available by way of property assets and pension assets, it seemed a good idea to look at. There was a pension policy which was introduced at the end of 1990s by a company called Cannon Lincoln, which has long disappeared into history in which the amount of pension payable would be variable, so that if there was a trigger, an event, which meant that care was needed then the pension would be increased, doubled or whatever. My understanding is that under Inland Revenue rules this was declared inappropriate and the product simply had to be removed. In order to enable a pension pot to be used for funding long-term care you would have to have a change in those Inland Revenue rules to allow variable payouts from pensions. Pension pots are viewed as being less promising at the moment because I think it is recognised that there is less pension money around.

Mr Horlick: I would agree that it is definitely something worth looking at and I would also agree that the Inland Revenue rules need to be changed in order to incentivise the industry to look at that. I think there is probably something in it.
Mr Laing: The figures I have quoted, we have a model for working out what a fair fee is. We look at all the costs. Our calculation is that for a provincial residential home outside the London area £540 a week would be a fair fee for a good quality care home that meets all of the most recent standards and £670 a week for a provincial nursing home.

Mr Laing: This is according to the report footnote referenced in the Green Paper. I would not say that that is necessarily an appropriate division.

You are expecting to buy at eight times their operating times multiple of operating profits. So if investors care homes? For a good quality care home at the place and say how much are investors paying for £75,000 per bed or something like that, then 12% on capital, so if you look at how much it costs to put a care home operation. The reason why is because of the capital costs of a care home. If we now look at the basis of what I have just said, no, the large corporates are making good profits but I would not say that they are making excessive profits.

Q582 Dr Taylor: Right. I think you also earlier on said that split pretty well half and half into hotel and care costs.

Mr Laing: Let us distinguish between return on revenue and return on capital.

Q583 Dr Taylor: What sort of level of return would you expect care home owners to get?

Mr Laing: An 12% return on capital is more reasonable. It is the only market-related measure of what a reasonable rate of return is of which I am aware. If you want to look at it another way and say why 12% when the bank rate is now 0.5%—because running a care home is a moderately risky business. Some care homes do fail; some care homes do close; you can mismanage it; it can all go wrong. You can take on a lease and be unable to pay your rent. That is the basis of it. If you think 12% is reasonable and all the figures flow through then you will come to a conclusion that a high 20s return on revenue is also reasonable.

Q585 Dr Taylor: Which I am only just beginning to understand.

Mr Laing: Earnings before interest, tax, depreciation, amortization (of goodwill) and rent.

Q586 Dr Taylor: Thank you!

Mr Laing: In other words, just call it operating profits.

Dr Taylor: This is the reverse of the question?

Mr Laing: Everyone has their own jargon!

Dr Taylor: The figures that were mentioned in the last accounts Southern Cross earned a 28% return on revenue and for Barchester it was 25% as well. The figure of 17% comes from Care UK but that is a mix of other services as well. I would say that a 17% return on revenue is totally inadequate for a care home operation. The reason why is because of the high capital costs of a care home. If we now look at return on capital employed, our fair price model assumes that a reasonable rate of return is 12% on capital, so if you look at how much it costs to put a care home into operation, you have to build it, you have to get the land, start-up costs and so on. I cannot remember the exact figure but it might be £75,000 per bed or something like that, then 12% on that gives you a reasonable profit level. That actually works out at something like the high 20s in terms of return on revenue, so a 12% return on capital is more or less a high 20s return on revenue. Why do we say 12%? It is very simple. You look out in the marketplace and say how much are investors paying for care homes? For a good quality care home at the moment post crisis crunch they might pay an eight times multiple of operating profits. So if investors are expecting to buy at eight times their operating profits, if you take the inverse of that, that implies they are looking for a rate of return of 12% on capital. It is as simple as that. It is the only market-related measure of what a reasonable rate of return is of which I am aware. If you want to look at it another way and say why 12% when the bank rate is now 0.5%—because running a care home is a moderately risky business. Some care homes do fail; some care homes do close; you can mismanage it; it can all go wrong. You can take on a lease and be unable to pay your rent. That is the basis of it. If you think 12% is reasonable and all the figures flow through then you will come to a conclusion that a high 20s return on revenue is also reasonable.

Q587 Dr Taylor: To William, we have talked about care home fees and I think you mentioned earlier £540 per week. You have got a way of calculating fair care home fees. Am I right on that figure? In your paper you go into more detail about different schemes.

Mr Laing: The figures I have quoted, we have a model for working out what a fair fee is. We look at all the costs. Our calculation is that for a provincial residential home outside the London area £540 a week would be a fair fee for a good quality care home that meets all of the most recent standards and £670 a week for a provincial nursing home.

Mr Laing: This is according to the report footnote referenced in the Green Paper. I would not say that that is necessarily an appropriate division.

Q588 Dr Taylor: Is there evidence that some of the larger corporate providers are making excessive profits?

Mr Laing: On the basis of what I have just said, no, the large corporates are making good profits but I would not say they are making excessive profits.

Q589 Dr Taylor: Not excessive?

Mr Laing: No.

Dr Taylor: For an economist to explain something that I actually understood is absolutely brilliant so thank you very much.

Chairman: Is this a first Richard?

Dr Taylor: It is a first, absolutely.

Charlotte Atkins: Mr Laing again, your report says that personal budgets “held by councils on behalf of users” are now being pushed because progress on direct payments has been so slow. Could you maybe elaborate a bit more about that? Is that because direct payments have failed? What has happened there?

Mr Laing: I do not think they have failed. If you take a direct payment that implies you take on all the responsibility as an employer and it is too much hassle for a lot of people to take on. Individual budgets are a way of extending the whole idea of having personal control over budgets but make it more hassle free.

Charlotte Atkins: So you think that would work better especially for elderly clients?

Mr Laing: Yes because then you have your individual personal budget which might be held by a local authority for example but is there for you to use without necessarily being an employer yourself.

Q590 Charlotte Atkins: Mr Laing again, your report says that personal budgets “held by councils on behalf of users” are now being pushed because progress on direct payments has been so slow. Could you maybe elaborate a bit more about that? Is that because direct payments have failed? What has happened there?

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Mr Laing: Yes because then you have your individual personal budget which might be held by a local authority for example but is there for you to use without necessarily being an employer yourself.
therefore they want to reduce their risks. What evidence is there of this? Again, this is anecdotal. We had a domiciliary care conference the other week and one of the people I was speaking to was a domiciliary care provider and he said if they lose a block contract that is not the end of the story for them. What they can do is go to their customers with whom they have a direct relationship and persuade them to move over to direct payments or individual budgets. In that sense, that reinforces the idea that the local authority cannot simply take a block of business away and give it to somebody else. Would it result in poorer value for money for local authorities? I think this goes back to a question that was asked of the previous witnesses, and to what extent local authorities are or should be using preferred providers. I think inevitably local authorities are going to seek to control the financial consequences of choice and the worry would be that individuals would take their own money and do their own deals with individual providers of domiciliary care services. Naturally local authorities are going to say that is fine but we do not want you doing deals which would raise the rate that is being paid from £13 an hour to £15, £17, £20 or whatever so inevitably local authorities are going to want to exercise some sort of control in terms of a list of appropriate providers who have agreed to charge within certain bounds. That is inevitable.

Charlotte Atkins: Thank you.

Chairman: That completes this session. I must say we have been super efficient. Thank you very much indeed for coming along and helping us with this inquiry.
Thursday 26 November 2009

Members present
Mr Kevin Barron, in the Chair

Charlotte Atkins  Dr Doug Naysmith
Mr Peter Bone  Mr Lee Scott
Jim Dowd  Dr Howard Stoate
Sandra Gidley  Dr Richard Taylor
Stephen Hesford

Witnesses:  Mr Andrew Harrop, Acting Charity Director, Age Concern and Help the Aged, Mr Stephen Burke, Chief Executive, Counsel and Care, and Mr Andrew Chidgey, Head of Policy and Public Affairs, Alzheimer’s Society, gave evidence.

Q593 Chairman: Good morning, could I welcome you to what is our fifth evidence session on our inquiry into social care? I wonder if I could ask you for the record if you could give us your name, and the current position that you hold.

Mr Chidgey: I am Andrew Chidgey, Head of Policy and Public Affairs at the Alzheimer’s Society.

Mr Harrop: Andrew Harrop, Acting Charity Director for Age Concern and Help the Aged.

Mr Burke: Stephen Burke, Chief Executive of Counsel and Care.

Q594 Chairman: Again welcome. I have a couple of general questions just to all of you, and we will get down to some specifics with individuals as we go through this session. I wonder if I could ask you, what do you see as the greatest shortcomings in the current social care provision that can be addressed by national reform?

Mr Harrop: It is obviously a very complicated picture at the moment, and I think the first problem with the system is complexity. It is impossible for a service user or their family to understand the entitlements and navigate the system. We also think that the coverage of support is far too limited, both in terms of eligibility criteria, which means you really have to be very disabled today before you get state funded care; and of course because the system is means tested, which not only means that some people have to pay quite significant charges, which they may find difficult to pay for, but it also turns away a lot of people who need help. Either people do not come and ask for it, or some local authorities just say, "You are over our thresholds, go and find your own support". Then the final big issue I would like to highlight is the issue of the amount of money spent per service user—of people who are in the system—which translates to the amount or quality of care that people can get. In the case of people living in their own home, care packages for older people are really very, very small compared to the levels of needs they have; and in care homes, we have a system where most local authorities across the country underpay care homes compared to the true cost of providing care.

Mr Burke: I would share that view. The system is extremely complex. People see it as being unfair, in the postcode lottery that Andrew talks about, in terms of what you get depends on where you live, and how much you pay also depends on where you live, but I think the issue of underfunding is critical, because obviously that underpins the postcode lottery, but also, for instance, it has a big impact on the growing number of self-funders, people who in effect are cross-subsidising their residential care home place, for example, for underfunding of local authorities, other people are being asked to make third party top-up payments and so on, so underfunding and a huge level of unmet needs, people who really do need a service who simply are not getting it at the moment.

Mr Chidgey: I think we have a lot of people who, with a little bit of help, well organised, could live much more fulfilled independent lives, whether they be living in their own homes on their own, or with family, or in a care home. I think what we have at the moment is very high policy aspiration, that describes fantastic outcomes that we want to achieve for people in terms of fulfilled lives, in connected communities, with all sorts of peer support networks, but we do not have the delivery. So that is the problem, the gap between the aspiration and the ability to deliver it. Of course it is partly about the lack of funding in the system to do it, but I think there are a whole range of things that this inquiry has already been covering in its sessions.

Q595 Chairman: I think we will take issues around the level of funding, the particular way social care is funded, means tested, and local variation, and effectively the potential rationing by the means of eligibility criteria, those are the areas of concern. Can I just ask you: how much unmet need is there currently, and for which group is it most acute?

Mr Burke: Sir Derek Wanless in his review for the King’s Fund certainly estimated that, but also the Commission for Social Care Inspection perhaps more recently talked about at least over 300,000 people with unmet needs, and that figure probably is an underestimate. There are a number of other surveys as well, but they tend to focus on particular local authorities, rather than the national picture, so I am very interested to see what the Commission for Quality Care are going to come up with in their forthcoming annual report.

Mr Harrop: Yes, that is right. I think the Wanless report remains the gold standard in terms of analysing levels of need and how the system is
Mr Chidgey: I think it depends on your level of ambition, does it not, really? Wanless described in his report a number of different models that we could aspire to, thinking about the funding, and he said that in the most advanced form, which I think is what maps to what the policy aspiration is in Our health, our care, our say, or Putting People First, he said that in 2007, there was at least a £3 billion funding gap, so that is in terms of money, but in terms of which are the groups of people where there is greatest unmet need, I think that if you look at people living in their own homes who are living alone, I think there is significant unmet need. I think if you look at people who are living in their own homes with a family carer, I think a great and increasing burden is being placed on families, because they are there, they are willing and they will do it quite often even though it may have significant adverse impact on their own health and well-being; and then in relation to care in care homes, at the moment, despite some positive work from regulation and improvement in some sectors of the care market, I think we still, as we know, see significant underperformance in helping people to live far better lives than they currently do.

Q596 Chairman: Would you agree that probably the biggest sector is people living alone at home?

Mr Harrop: They are all important, are they not? People living at home are the most vulnerable and isolated, and it is extraordinary that there are tens of thousands of people with disabilities who do not get help from anyone, but I do not want to ignore the other two sectors.

Q597 Chairman: I accept that, we were just trying to focus on where we think the unmet need is. You will have seen the evidence we have been taking in the last few weeks, and measuring it is difficult in itself.

Mr Harrop: It is also the reliance on family carers, where people are being expected to pick up the care responsibility and not getting any help from their local authority, as well as isolated older people.

Chairman: We will probably look at one or two of those areas as we go through the session.

Q598 Sandra Gidley: How prevalent is poor quality social care, and are you able to give us any examples?

Mr Burke: I think there are a number of particular areas which we would point to which are certainly raised time and time again through our advice service; first of all, in terms of people who are using home care services, it is the way care is commissioned and provided, so when people are being given a 15 minute slot with a home carer, it is simply not enough to meet even their most basic of needs, let alone develop a relationship with that carer, which a lot of people say they want; and also not just 15 minutes, but it is the timing of that care, so being expected to go to bed at 6.00 in the evening or get up at 10.00 in the morning. Linked to that, I think, is the issue about continuity of carers as well, and I think that is particularly important for people with dementia, in terms of familiarity with their carer; also the level of training that is available, particularly for carers of people with dementia as well. The other big area that we get a lot of concern about is in residential care, where simply again not enough notice is taken of residents’ wishes, in terms of their choice of activity, timing of when they eat, and so on, let alone respect of their own culture and food and things like that. So I think personalisation has a long way to go in terms of improving the quality of care for people living in their own home and in residential care.

Q599 Sandra Gidley: Are you saying personalisation may be more difficult in a care home setting?

Mr Burke: I think it is not nearly as advanced in residential care as it is for people living in their own homes.

Q600 Sandra Gidley: Interesting point, Andrew, anything to add?

Mr Harrop: Yes, I want to comment on personalisation in care homes particularly, because when you look at Putting People First as an agenda, it does not equate personalisation with personal budgets, but that is the way it is often being seen on the ground. The philosophy of personalisation is just as relevant to care homes as it is to people living in the community. All the things that Stephen talked about is actually about rethinking how services are delivered, thinking about the dignity and independence of a service user, as much as it is about extra money. I am not saying that care homes are not underfunded, they are, but there is a lot that can be done in terms of better staff training and motivation, so that they feel like they have a real mission to support independent lives, even for very vulnerable people in institutions.

Q601 Sandra Gidley: So is it not just about money, it is about the whole attitude?

Mr Harrop: It is about ethos, a sense of empowerment and dignity for all service users.

Mr Chidgey: If I can give you a couple of examples that we are currently seeing in relation to the experience of people with dementia and their families, I am sure you have many in your constituencies, but I think a typical example is a lady who was talking to last week, who said as a family, we are trying to support our mother, my mother, who is living 15 miles away, someone from the family drops in every day. She is now developing into the middle stages of dementia. We think she is able to cope well on her own, and she desperately wants to stay in her
own home, in her own community, and we think that with a little bit of help, apart from what the family can provide, through some reminder services, some help to get her up in the morning, and make sure that she has had some breakfast and is ready for the day, that she could continue to live independently. Unfortunately, the response from the services that are available seems to be that they can only go in at specific times of day. So the daughter was saying, well, you know, they go in at 10.30, and she has already gone out for the day, she has not been washed, she has not had anything to eat, and what happens is we will get a call from someone to say she has been found somewhere upset, disorientated, dehydrated. I think there are lots of cases where you cannot always resolve all of these problems, and you just have to make do as best you can, and they are looking at whether they can get personal budgets, but I think there is still a lack of ability to respond to the very good policy direction that is set, and there is the big glaring funding gap problem. I think one of the things that is missing in all of the proposals for the Green Paper, actually whichever political party you look at, I think is a clear explanation about how we are going to develop a workforce to support people, which is actually equipped to do that, and is actually remunerated in a way which recognises the skill that is required. I am going to stop because I do not want to go on too much, but I think we are going to continue papering over the cracks if we just think that personalisation is going to resolve everything, because clearly it is not, is it?

Q602 Sandra Gidley: So you would agree with the previous witness, who said that announcing policy is the easy bit, I am paraphrasing slightly, but that delivery is not on the same level.

Mr Chidgey: I think it would be unfair to say that announcing policy is the easy bit, it is more like getting them up in the morning, washing them, feeding them, sitting them in front of the television set and putting them back to bed again? We will not give you that package we assessed you for; we will not give you attendance at night, and instead we will make you wear incontinence pads all night rather than help you go to the toilet, even though you are not incontinent”. That is a shocking example of age discrimination in practice. It really shows that it is also about assumptions, the outcomes people expect for different age groups are really different; and that feeds through into how assessments are made, and also, in the world of personal budgets, the resource allocation for those budgets. There is now growing evidence that people with the same levels of needs are getting different levels of personal budgets just because of their age.

Q604 Mr Bone: Very interesting that there is now actual evidence, because it has tended to be stories in the past, but now there is hard evidence.

Mr Harrop: The Department of Health put a number on this 18 months ago, they said to move from today’s system to a completely age equal system could imply around £2 billion of extra spending.

Q605 Mr Bone: So you could argue that older people are losing out to the tune of £2 billion per year?

Mr Harrop: You certainly could.

Q606 Mr Bone: Is it just the budgets? We now have clear evidence, but is there something more to this age discrimination, are people being treated differently because they are older?

Mr Harrop: I think there is a set of assumptions about older people and their expectations around independence in their own home, and about the sorts of social activities that they will want to participate in. With younger disabled people in the care system—and this has moved a huge amount in the last 20 years—there is a real ethos of trying to give people as normal a life as possible; of seeing things like work, leisure activities and social opportunities as really being a core part of what the care system is there to do. That just is not true for older people. The ethos sadly is much more about health and safety; ensuring harm does not come the way of an older person, rather than trying to help them live their life to the full.

Q607 Mr Bone: It is more like getting them up in the morning, washing them, feeding them, sitting them in front of the television set and putting them back to bed again?

Mr Harrop: Stephen talked about 15 minute visits once or twice a day, unfortunately that is all too common.

Mr Bone: I know that from personal experience. Thank you, Chairman.
Q608 Mr Scott: What do you make of the policy set out in the Queen’s Speech providing free personal care at home for those with the greatest need? What level do you think that need should be provided for, and can you see some unintended consequences of it?

Mr Burke: Certainly there are merits in the proposal, in the sense that it highlights that care is a major priority for the Government, and improving care is a major priority for the Government. Also, it is about trying to tackle some of the postcode lottery that we talked about earlier, and ensure that wherever you live, you will be entitled to free personal care if you have high needs. It also raises the issue about how we fund care in the future. This demonstrates that taxation might be part of the response, but, and there is a big but, the question is where are we heading generally, because we are obviously halfway through a Green Paper consultation on the future of care which is talking about system-wide reform, and that is what we need, we need to reform across the whole system. So a piecemeal change is not necessarily the best way to approach this. As you suggest, it may have unintended consequences, so hard-pressed local authorities being expected to find quite a lot of extra money to fund this might instead cut services to people with lower levels of needs, or they might try and place people in residential care rather than supporting them in their own home.

Mr Harrop: It is a really welcome move forward, but we need to see it as a stepping stone to ‘whole system’ reform, rather than being something that will work in the long run on its own. I think there is quite a lot of uncertainty in how the policy is going to play out. Firstly, we really do not know how many people are going to be eligible for this extra support, partly because of the people who are not covered because of means testing today; people who are above the threshold or just do not come forward to ask for help. So people will come out of the woodwork. But also we do not know quite where the level of eligibility will be drawn. From what we saw just yesterday, when the Department published its consultation, you really will need to be very, very disabled and in need to get this free offer. I will not go into the detail of the assessment process, but basically there is this level of need called ‘critical needs’ that you will need to meet, and you will also need to have four ‘activities of daily living’ that you cannot do—that is things like being able to wash yourself or dress yourself. So the people who are going to be supported by this actually could be relatively few in number. For example, that story I told you about in the McDonald case—the woman with a £700 per week package of care—she was not actually assessed as being in ‘critical need’, she was assessed as being in ‘substantial need’. So there you have an example of someone who clearly has huge care needs and a huge package of support which she was assessed as needing. She would not necessarily be covered if we just transplanted today’s system into the future with this new piece of legislation. There is complexity in how the policy is going to be implemented locally.

Q609 Mr Scott: Can I just add one extra part for yourself: do you have any particular concerns about the possible impact for people with dementia?

Mr Chidgey: Yes, in terms of the proposal that is on the table, I think what would be very good is if you could see some of that money supporting people who have perhaps very low level needs, rather than just trying to concentrate all the funding on people at the severe and the substantial end. I think if we are going to begin moving towards the policy direction set out, I think we need to try and in some way make sure that there is that low level support available, and if providing some free support to do that can move us in that direction. I think it would be a good thing. In terms of people with dementia, I think what we currently see now is—we have moved to a very different place in the last 20 years, in terms of the types of people who are now going into long-term residential care. I mean, there were studies back in the 1980s showing that probably perhaps 20–30% of people in care homes had a cognitive impairment; it is now well over two thirds, and in many cases 70–80% of people with a cognitive impairment. So long-term care is now much more about specialist dementia care, and in terms of this discussion about free personal care at home, of course what we need to try and do, as far as possible, is support people with dementia to live independently in the community with their families hopefully, where possible, but I think we need to make sure that where long-term care is necessary and actually is the best option to promote the well-being of the person with dementia, and perhaps their family as well, that is an option that is available. So I think the worry for me is: does the policy create perverse incentives to either admit people to long-term care too early, because perhaps there is a local authority incentive, or does it incentivise people to keep the person with dementia at home for longer when actually it is not good for that person’s quality of life, or for the family’s quality of life? So I think there are some serious worries. I think the big question overhanging all of this though is that at the moment, when we talk to—we have talked to thousands of people with dementia and carers over the last two years about the ways you can change care and the funding of it, and the big worry for people is not of course just about where is the money coming from, it is what you are going to get. So I think although it is good to see proposals about free care and changing the system of charging, the big worry for people is there is nothing in the proposals that they think very clearly describes: what are you going to get? Are you going to be able to get some respite care except in an emergency, which is often the case at the moment, some planned respite? Are you going to be able to get a little bit of help to get someone out of bed, and to involve them in some meaningful activity? So I think quality is one of the big gaps.

Q610 Chairman: Could I just ask you, Andrew Harrop, you mentioned the consultation document, the written Ministerial statement that followed it talked about that people who currently have free care will have their savings protected from future
Q612 Stephen Hesford: Richard, I do not agree with the Labour Peer who said last week, "This is the first example of an Admiral firing an Exocet into his own flagship"?

Mr Harrop: I do not agree. Lord Lipsey was obviously heavily involved in the Royal Commission a decade ago.

Q613 Chairman: We can have that debate later, let us see what the witnesses want to say about it.

Mr Harrop: There is a perfectly good debate to have, about whether you should provide the entire costs of care to everyone living in a home, or perhaps ask for a co-payment, which is what Wanless suggested. But the reason I do not agree with Lord Lipsey is this policy is for very, very disabled people only. Most of the costs of care are actually care homes rather than personal care, so it is a relatively small part of the budget. It is also reasonably well targeted, because most of those people who currently are not eligible are actually on quite modest incomes compared to the whole population, simply because older people’s average incomes are relatively low. The regulatory impact assessment published yesterday says that most of the beneficiaries will be in the third income quintile of the whole population, they are not super-rich beneficiaries.

Q614 Dr Stoate: I want to stick with Alzheimer’s or dementia in general for the moment, and I am particularly interested in the interface between health and social care, something this Committee has looked at in the past. We were at that time struck by the force of the Berlin Wall that existed between the two. Has that improved? Particularly in relation to dementia, is there still that division between health and social care, or are they blurring a bit?

Mr Chidgey: I think in some cases it has improved. I think where you have formal structures and individuals in place who have specific responsibility for ensuring that there is joint commissioning, I think you are seeing some benefit, because it is their responsibility to make sure that services are working together effectively. For someone with dementia, it can mean that, for example, when someone goes into a care home, if they have had an adequate diagnosis, that actually, it is effectively recorded in their notes that there is sufficient information passed on to the staff team, or indeed if they are going into a hospital that happens as well. So I think the sharing of that information can significantly improve the quality of experience for someone with dementia, wherever they are. But, of course, there is still a very big battleground around NHS continuing care, and significant arguments that still go on where people feel that actually, they are in the middle of a tussle between two services who are trying to disown them. We are still hearing about examples where people’s continuing care funding is no longer available because they have been judged as not meeting the criteria, and yet there is not a care package effectively being brought into place to help people. So I think there is still a big Berlin Wall, and I think in relation to the proposals that the Committee has been discussing, I think there is the serious question about if you have a national health service and a national care service, how are you going to make sure that the integration is effective?

Q615 Dr Stoate: That is interesting. So what do we know at the moment; for example, what happens when a person with dementia goes into hospital, do we know much about what happens to them?

Mr Chidgey: Yes, we know more than we have done before. There have been a number of studies published in fact in the last couple of months that have shown what the experience is. So for example, we know that about a quarter of all people in hospitals at any one time are people with dementia. In fact, there was a very good study done by a researcher called Liz Sampson that showed that half of all people over 80 in hospitals have a form of dementia, so we are knowing more and more about the fact there are significant numbers of people. We also know that they are staying significant amounts of time, much longer than other people who go in for the same treatments or procedures. So if you go in for treatment for a urinary tract infection, for example, whereas the median length of stay might be, for example, a week, for someone with dementia, it could be three weeks, four weeks—

Q616 Dr Stoate: But how much of that is due to their medical condition and how much of that is due to the poor interface between health and social care?

Mr Chidgey: I think there is a general problem across both health and social care about lack of knowledge and skill in relation to supporting people with dementia, but I think that actually, if you, for example—I think that probably it is inadequate discharge planning where the biggest problem happens.

Q617 Dr Stoate: There is still the problem, in other words, with getting people better in hospital, and then what to do with them afterwards.

Mr Chidgey: Yes, making sure they can be effectively rehabilitated in their own homes, or that they are found a supportive environment in a care home.
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Q618 Dr Stoate: We have already heard this morning that a huge burden of social care is to do with people with dementia related illnesses. Are there any breakthroughs that you know of coming up in the future that might change the whole equation in the coming years?

Mr Chidgey: When you talk to the dementia research community, what they will say is there is not likely to be a cure on the horizon in the next 15 years; however, what they do say is that they are quietly confident that we may see some disease modifying treatments, so that is to say although people may continue to develop diseases in the brain that cause dementia, we may be able to significantly modify the progression of the disease which will mean we may be able to keep people earlier in the condition with less significant symptoms than we are at the moment. Because at the moment, you can have a very different journey through dementia, as you will know, where you might start developing symptoms and die within four or five years, or you may die within 10 or 15 years, by which time you will be having significant care needs. If we can delay the onset of progression of dementia, then I think that is probably where the most significant opportunity lies.

Q619 Charlotte Atkins: I would like to ask about Attendance Allowance. What information do we have on who claims it, and what it is spent on?

Mr Harrop: I think that other submissions have provided you detailed modelling on the different income groups who are claiming it. There does seem to be evidence that it is a reasonably well targeted benefit, in terms of which income groups receive it and what their incomes would be without it, taking into account the cost of their disability. We did our own research about 18 months ago looking at people who had newly claimed Attendance Allowance, having been through an Age Concern advice service. Over half of them that they used the money for help around the home or with the garden; a quarter said they used it to get help with care; and around 20% said they got health-related equipment and adaptations or other household equipment or household repairs. Those all seem to be eminently sensible things to be spending their Attendance Allowance on, and very much fit with its description as a resource to help with the extra costs of disability.

Q620 Charlotte Atkins: The Department of Health seem to think it goes on Saga cruises, is that true? And if it was true, does it matter?

Mr Burke: Actually, Attendance Allowance is almost the original personal budget, so in a sense, we have other examples about the way personal budgets are being used, but the key point about it, as Andrew was saying, is that 1.32 million people in England over the age of 65 are claiming Attendance Allowance. It is very popular, obviously because it is not means tested as well, but look at other groups, so people, for instance, with sensory impairment who rely on Attendance Allowance to help with mobility, with communication and so on, are extremely worried about the prospect of losing that, and not certain what they are going to get in return. I think that is the big issue for a lot of people, if we are going to lose Attendance Allowance, what is it that the new National Care Service will deliver in return? There is no clear evidence, from the fact we have not had the modelling either, to suggest what it is that people will be offered.

Q621 Charlotte Atkins: Do you think it is sufficiently claimed? Do you think there are still a lot of people out there who are not claiming it? I certainly, in my case load, find quite a lot of people who really do not know about Attendance Allowance, and are not aware that it is not means tested, because obviously there is a reluctance to go down the route of applying for something which might be means tested, and are not fully aware that this is not means tested. I know that Age Concern do a fantastic job encouraging people to take up these benefits, but very often, unless—and I use the service all the time, I try and get people to talk through those issues, but what is your sort of impression about whether it is being sufficiently claimed?

Mr Harrop: I am sorry, I was just looking through my notes, because I thought I had a number on the estimate of underclaimed Attendance Allowance. But it is very significant, particularly with the over 80s, where an awful lot of people have levels of disability that would warrant a claim. You are right to say that local advice services like Age Concern play a critical role. They try to look at the whole person, and think about all the different types of support and entitlements that they can be helped to access, be that through social security, local government, or the health service. Information and advice does play this critical role in wrapping together all the different sorts of support and then making sure people care what is their due.

Mr Chidgey: I just wanted to add, I think there was some quite interesting discussion going on in previous evidence sessions about whether the support that people currently get through attendance allowance would be protected under a national care service. I just wonder what that protection means, whether it means protection of the financial value or the support that people would get, and also whether it means protection for people who are currently getting Attendance Allowance, or whether it means protection for all people who might be judged to be in the same needs category in the future. I think one of the big issues here is that if you—and I am sure you will have had it in some of the evidence, if you currently do not meet any of the criteria for local authority funded care, you still might be eligible to get Attendance Allowance. So at the moment, the reason people are getting so angry and heated about this, is partly because they are often being assessed and then being told, no, you do not meet the thresholds for any help, but they still do nevertheless get Attendance Allowance, which is helping them cover the costs of disability and living a better quality of life, and they do not see the guarantee about what you are going to get in return, and there is this great fear. The biggest response we
Could you run through the Q624 Dr Taylor:
up right, so that it is easy .
Mr Harrop: We need to be very careful that we set it.
Mr Harrop: That is not impossible under a new national care
of people with an entitlement are actually claiming
need to try to make sure that the maximum number
way that care and support from your council is. We
system. It is not administratively bureaucratic in the
assessment, is that this is a very easy and flexible
problem of a national care service, as long as the underlying
payments, so that they could come under the banner
into a new system; but we are not
carry forward in a new system.
Mr Harrop: Andrew is absolutely right. Stephen
mentioned people with sensory impairments, but the
other key group is people with family carers, because the
suggestion is—Attendance Allowance is carer
sighted; in other words, if you have got family care, you
would not receive help with the cost of your
disability through the new system.

Q622 Charlotte Atkins: What evidence is that
based—that is just supposition at the moment, is it?
Mr Harrop: No, that is what the Department have
suggested through the analytical work underneath
the Green Paper.

Q623 Dr Taylor: Really going on on the same
subject, you have said the benefit is that it is carer
blind; could there not in fact be gains from making
this better targeted? Is it not poorly targeted at the
moment, because it is available for virtually
everybody? Could there be gains if it was better
targeted?
Mr Harrop: Specifically thinking about carers, this
benefit to help with the extra costs of being disabled,
the sorts of things I talked about, and I do not think
these disappear just because you have family care. I
think the concern about reforming Attendance Allowance, as well as what Andrew said about the
assessment, is that this is a very easy and flexible
system. It is not administratively bureaucratic in the
way that care and support from your council is. We
need to try to make sure that the maximum number
of people with an entitlement are actually claiming
it. That is not impossible under a new national care
service, but we need to be very careful that we set it
up right, so that it is easy.

Q624 Dr Taylor: Could you run through the
guarantees? In your paper, you give us four or five
conditions. Could you go through those?
Mr Harrop: Well, I guess those five conditions really
describe what Attendance Allowance looks like
today. The reason we set it out as a list is that our
basic position is that we want to see the statutory
entitlements which are in Attendance Allowance
carried forward into a new system; but we are not
opposed to a repackaging or a rebadging of those
payments, so that they could come under the banner
of a national care service, as long as the underlying
entitlement remained. So we do not have any
problem with, for example, a single assessment
process, as long as the entitlements that it gave you
were the same; or a personal budget which included
your old attendance allowance component and your
social services component combined, as long as our
conditions were met, in terms of it being based on
entitlements; a minimum weekly payment that does
not decline compared to today; being carer blind;
being completely flexible, so you decide how you use
it. Those are the sorts of things that we think need to
carry forward in a new system.

Q625 Dr Taylor: Still with you, we are told that last
week you welcomed the Conservative Party’s commitment not to reform disability benefits at all.
Mr Harrop: What we welcomed was the commitment to the underlying entitlement that is in
Attendance Allowance. In all our public statements,
we have said that we want to see that statutory
tenure stay in any new system. However, we are
prepared to see that sort of rebadging that I talked
about. So we are up for a debate about better
integration, so that you go to one person and they
tell you all your entitlements—and it can be called
the national care service. What we are opposed to is
the sorts of things that have been proposed about
moving to carer sighted eligibility; needing to be
disabled than you are today; and about it being
measured. All those proposals do seem to be live
in the Department’s thinking.

Q626 Dr Taylor: So as long as the carer blind
equivalent remains, whatever it is called, you would
be happy?
Mr Harrop: And non-means tested, yes.

Q627 Dr Taylor: Any views?
Mr Burke: Let us not underestimate the depth of
feeling about this issue that has been stirred up in the
consultation process to start with, and the fact that
many people getting Attendance Allowance
currently fall outside eligibility criteria at the
moment. I think that is the big concern, people think
a new national care service will have similar
eligibility criteria, and they will not be entitled to
help under the new proposals, and therefore feel they
are going to give up something without getting
anything back, so we need to see much more
evidence in terms of modelling and the kind of
guarantees that Andrew is asking about. I do think
though, if we are looking at long-term reform of the
social care funding system, we do need to look at
how we move towards a single pot of money that
pays for care and support, and we need to define that
quite broadly in terms of the level of support. That
is what has happened in a number of other countries
where they have reformed care, they have moved to
a single pot, a single funding stream. The question is,
why has Attendance Allowance on its own been
singled out to put into this pot when there could have
been a whole range of other sources of funding
which could have been added in as well. There is no
guarantee that that pot will keep pace with the
growth in demand in the future and so on, so people
are right to be worried about what they are going to
get in the future, and why they should be asked to
sacrifice Attendance Allowance.

Mr Chidgey: I think it is really important to
recognise that families are the people who are
providing significant amounts of care round the
clock, and they feel quite angry because they feel
they get a little bit of help, but actually there is a
proposal to take it away. When there are no
guarantees about what you might get instead, naturally, you grab at what you have got, and try and protect it, and I think that is the right response in the current circumstances, where there are not clear guarantees about what you are going to get. So I think there is a very rational explanation as to why you might think about having various pots of money drawn together to think about people’s needs in the round, and to make sure that they are being supported, to make sure it is about the best things to use it for, but at the moment, there are no guarantees about particularly people with low level needs, and the clarity that you are going to be able to make choices with that money.

Mr Harrop: Can I briefly make two further points about Attendance Allowance? Firstly ‘passporting’, by which I mean that Attendance Allowance gives you entitlement to other things. It gives the carer entitlement to Carers Allowance, and it gives people with disabilities entitled to increments on their means tested benefits—Pension Credit, and other entitlements. Secondly, age discrimination: the Secretary of State at the National Children and Adult Services Conference last month said that under 65s’ benefits would not be touched. We are very concerned about widening age discrimination in the care and support system. Whatever funding mechanism emerges, we will oppose any system where the outcomes that it aims to achieve are very different for different age groups. We worry that this could happen with these proposals.

Dr Taylor: Would the two Andrews agree with Stephen in his submission, “The care challenge is an issue for every citizen, we need a huge public debate and national consensus about the best way forward for all of us”?  

Q628 Jim Dowd: And are you against sin?
Mr Chidgey: Well, yes, but I think that the thing that is a bit missing in the discussion is I think there is often a great concentration, what are we going to do to sort out our care services and our healthcare services, when actually the answer lies in how do we—where we have significant numbers of people with long-term conditions, that are having an impact for them on a daily basis in all the interactions that they have with people, I am thinking particularly of cognitive impairment, of course, but it relates to a number of conditions, that the most effective response to support people can only come from people themselves, from their families, from their communities, and from some specialist support from services. So I would like to see a bigger debate, because I think we need to understand how communities as a whole can support people to live effectively. I know it is a big aspiration, but I think that is what we need to do, and I think that is not currently contained effectively. What is the role of voluntary workers, for example?

Dr Taylor: I think we are actually coming back to something on this.

Q629 Stephen Hesford: Andrew, just remind me, what is the current rate for Attendance Allowance?

Mr Harrop: It is £70 at the higher level of need and £47 at the lower level of need.

Q630 Stephen Hesford: You see, one of the difficulties I have with this discussion is in my postbag, I have a significant elderly population, nearly 25%, I have had virtually no postbag about Attendance Allowance going at all, and that interests me. In fact, what I have had anecdotally, certainly in the earlier years when I was elected, is people would complain about the amount Attendance Allowance was, that it was not enough, and some people said, “Well, I do not bother claiming it”. Yes, this is anecdotal to me, but I am just slightly confused as to why this agenda appears to be kind of special pleaded, and whipped up in a way; on the ground, I just do not see it. Can you help me?

Mr Harrop: Well, in terms of ‘on the ground’, I am quite pleased that people are not coming to you, because what we do not want is lots of very anxious people worrying that their money is about to disappear overnight.

Q631 Stephen Hesford: That is how it is being reported.

Mr Harrop: That should not be the case.

Q632 Stephen Hesford: That is exactly what the press and others are saying.

Mr Harrop: Indeed, and I am really glad that that is not playing through locally.

Q633 Stephen Hesford: That is why Richard used your quote before.

Mr Harrop: All the debate is about a long-term reform, rather than overnight changes. To the Department’s credit, it has said that there will be transitional protection for people currently receiving these entitlements. The concern is what happens to the person who becomes disabled in five years’ time, and what support they will get.

Q634 Chairman: Andrew, could I just ask you, you gave a list of where you think Attendance Allowance is spent at the moment; if the flexibility was taken away, would you as an organisation feel competent in arguing the point that gardening costs is something that should be part of a national care plan?

Mr Harrop: Well, this is a debate about personal budgets as well as Attendance Allowance, to what extent should a social worker or some other professional dictate what you should spend your resources on? There have already been some relatively controversial cases of use of personal budgets. Attendance Allowance was designed in the 1970s to give complete flexibility, so people would decide for themselves what would increase their quality of life. I think if you live in a family home with a garden, and you can no longer manage the upkeep—compared to the costs of having to move home, or the disruption that that might cause—I
think there is sometimes a case for relatively modest levels of help around the home and garden coming from social security.

Q635 Jim Dowd: You will have to excuse me, my previous comment was—I sometimes think when people ask for a national debate, they do not want a debate at all, because we can debate things forever, what they actually want is some conclusions. We need to also clarify what people’s approach to reform is; often as not, it is more, we will take what we have got now, and we want some more, and what we have got now becomes inviolate. I am not clear yet whether that is the position you are adopting. If I could just ask a couple of questions before I get to the main thrust, Mr Harrop, you mentioned the McDonald case a couple of times, which authority was that?

Mr Harrop: Kensington and Chelsea, but I do not want to single them out.

Q636 Jim Dowd: You just did!

Mr Harrop: I think councils are under enormous pressure. They are stuck in the middle. So I think it is dangerous to blame local authorities for having to administer a system that is not working.

Q637 Jim Dowd: So you do not actually think there was anything wrong with the decisions they took?

Mr Harrop: I am sure things were wrong with the decision. I am just saying they are partly to blame, they are not entirely to blame.

Q638 Jim Dowd: We all know how hard up Kensington and Chelsea is, they are really strapped for cash, so it must be difficult for them! Mr Burke, you mentioned postcode lottery, you are the only one who has, actually. There are 152 social care authorities in Britain, how do you reconcile the priority, or which do you regard as a priority: local commissioning, based on an interpretation of local need, or uniform provision, which authority you are saying, other than the fact you want the world to be perfect, which is highly unlikely, what are you actually saying? Which is the preferred model, the uniform provision or local commissioning?

Mr Burke: No, I think the National Care Service is the preferred model. That does not necessarily mean a kind of Stalinist uniformity across the whole country though, it is about making clear what people are entitled to wherever they live, and the kind of support that they should be able to access, whether it is about information and advice, as a starting point, but it is also about having a single assessment process which applies across the whole country. We have that at the moment, for instance, with the NHS continuing healthcare, it is still not 100% perfect because there are still local interpretations, but at least it is a move forward from where we were before, where we had every PCT doing their own thing.

Q639 Jim Dowd: You used the term, how do you define it?

Mr Burke: It is about being eligible for different levels of service and having to pay different levels of charges, depending on where you live. Now we very much support the proposal around developing a national care service, which has a range of universal entitlements, which would apply wherever anyone lives in the country. Now it is crucial that we have a strong national framework to do that, but it would still have to be locally delivered and responsive to local circumstances and local needs, and there is no reason why that cannot—

Q640 Jim Dowd: That would create differences from one area to another. You used the term postcode lottery in an entirely pejorative sense, to imply it as a bad thing, full stop.

Mr Burke: The two key things are that wherever you live, you would know what you would be entitled to, regardless of your local authority; and secondly, it is crucial that people—this is particularly true for younger disabled adults, if you move, you should be able to go to somewhere else and get the same kind of level of support that you are currently entitled to. That is what people say to us the whole time, that they expect that consistency to be available. It does not mean that the actual delivery of service will be exactly the same in Kensington and Chelsea compared to Keswick in Cumbria.

Q641 Jim Dowd: I am still not clear from what you are saying, other than the fact you want the world to be perfect, which is highly unlikely, what are you actually saying? Which is the preferred model, the uniform provision or the taxation option, which has been ruled out by—

Q642 Jim Dowd: Which of the funding options in the Green Paper do you favour, if any?

Mr Burke: We have favoured either the comprehensive option or the taxation option, which has been ruled out by—

Q643 Jim Dowd: This is based on essentially—

Mr Burke: The comprehensive option, I would argue, and taxation are two sides of the same coin; it is a question of how the comprehensive option could be fairly funded. We have certainly made a proposal which would be a lot fairer than the kind of media headlines which are suggesting that everyone pay £20,000 at the age of 65 regardless of their circumstances.

Q644 Jim Dowd: Mr Harrop, you say that the comprehensive option would represent less value for money for many people, so clearly you do not favour that.

Mr Harrop: No, we are quite concerned about the comprehensive option, and it is tied up with the discussion we have had about Attendance Allowance being used to pay for it. Take someone who is of middle or high income who might be expected to pay the £20,000 or so payment to get their entitlement to free care; they would also lose Attendance Allowance, which over the life of a claim
also adds up to around £20,000, if you claim for around six years, which is the average. So you have foregone £40,000, potentially. In exchange for that, you would get free care. But today, you can buy an immediate needs annuity from the market—not many people do, but insurers will provide it—and that costs around £80,000 for the full costs of a care home for life. The current proposals are only covering care and not accommodation, which is about half the costs. I am in danger of overcomplicating, but basically, if you need care tomorrow and just want to pay for your care costs and not your accommodation, it would cost you £40,000 at the point of need. This is compared to the £40,000 you may potentially forego in the future not even knowing whether you are going to need a care home—because this is, of course, based on risk; some people will need it and some people will not. So it just looks like a bad deal. Does that make sense? Sorry, it is a complicated answer.

Q645 Jim Dowd: In part, yes, it does, but I am not sure why the immediate needs annuity insurance that you referred to just then would be more predictable than the comprehensive approach?

Mr Harrop: It is not. Immediate needs annuities are products on the market at the moment; if you are disabled and going into a care home, you have the choice of buying one of these annuities. £80,000 is an awful lot of money, so most people do not. But it is a way of insuring against the long tail of care costs, in case your care home costs you over your life more than that amount of money.

Q646 Jim Dowd: It costs £80,000 over what period, or upfront?

Mr Harrop: Upfront for life. So you sell your home typically; you pay £80,000 and you put the rest in the bank and you give it to your children; that is how they work. It is a minority choice, very few people do that, but it is already available. I am saying that I am not sure many people, looking at the option of the comprehensive model, would actually conclude, if they knew about immediate needs annuities, that the offer from the Government was a better bet.

Q647 Jim Dowd: Would you hazard that that may be because of the recent social phenomenon of more and more people, that they expect an inheritance these days in a way that previous generations never have?

Mr Harrop: I think part of the debate is about what is an appropriate use of housing assets, and should people expect to pass this on in its entirety to their children and grandchildren, or spend it on themselves in their own lifetimes. I think there is a perfectly good argument to have that more of that housing money should be spent on yourself. The problem is that the current proposal to tap a big lump sum at 65 feels administratively and politically very difficult. I would much rather see less obtrusive ways of taxing or making charges on assets in general, including perhaps inheritance tax; but that is a very politically difficult area. In general, are there ways we can tax assets better, rather than just a highly visible one-off charge at 65? I think the politics of this proposal are very difficult.

Mr Burke: I agree with Andrew about 65, which is why we propose this notion of a care duty, which is 2.5% on people’s estates, obviously that would reflect their assets and wealth and so on at death. It has a number of merits, because obviously it is linked—we have collection mechanisms anyway, obviously it links mainly what is end of life care to death, it would keep pace with the growing aging population and so on, and the critical thing is it would enable people to protect most of their inheritance, but it would still ensure that people’s contribution did actually reflect the value of their estate. I think one of the other key things is it has to be hypothecated, so actually, 2.5% on estates would generate enough income to meet the kind of care funding shortfall that currently exists, and if it was hypothecated, I think people would wear it, as a fairer way of paying for care than currently exists.

Q648 Jim Dowd: 2.5% across the board, on all estates?

Mr Burke: You could start at a certain level, so the first £25,000 perhaps of estates would not be covered, then you pay 2.5% thereafter.

Q649 Jim Dowd: So it is just the generality of taxpayers who are paying this, rather than specific receivers of services?

Mr Burke: Yes.

Mr Harrop: I think the key thing is pooling risks. Thinking about people outside the means tested system today, all the research we have done has shown that people do not like the lottery where you either pay nothing for care or a great deal. Moving towards a system where everyone pays a bit seems to be popular in principle, but the devil is in the detail of what is an acceptable charging mechanism.

Mr Chidgey: I think there is a mistaken view sometimes, there is a polarisation here between people who think that the state should pay everything and people who think that everyone should pay for everything themselves, when actually, most people that we talk to, even those who have had to endure quite high care bills, say they think it is fair for people to make a contribution towards the costs of care, but they want some clear guarantee that they are going to get good quality. Back to your question about inheritance, I think there has been a big change in attitudes for society as a whole, if I can put it that way, because I think if you think back 10 or 15 years ago, when there were still a lot of discussions about how do we sort this out, I think there was very much more a view that this was a middle class issue, about being people worried about very well-off people passing on inheritance to their families. Now, of course, some people still take the view that that is what this debate is about, but actually, with the levels of home ownership that we are now seeing across all social groups, this is a problem that is facing families of all sorts of means. So where I wanted to respond was in relation to which model is preferred, and the view that we have
taken for the Alzheimer’s Society is that at the
current time, we do not support any of the models
that are being proposed, because the debate itself has
been set up as trying to secure a long-term settlement
on the future of the care and support system.

Q650 Jim Dowd: So your model is?
Mr Chidgey: Our model is that we want the
Government to describe in some detail what people
are going to get in terms of guarantees, will there be
available good respite care, will people be able to
get—

Q651 Jim Dowd: I was asking what your funding
model is, if you say none of the ones on offer are
any good.
Mr Chidgey: Well, the assumptions that are built in,
we think, are about a care system that will not deliver
good quality of life for people, so it is really neither
here nor there with what the funding model is. If
there were guarantees that there would be better
funding available, and better quality of care
available, then I think we could have a sensible
discussion about which model. I mean, people in
principle, when we talk to them, when we said to
them, well, if you had a system where you could be
guaranteed better quality of care, which would you
like, people with dementia and carers tended to opt
for the comprehensive model, but it was still only
25–30% of people, and even then, when you came
back to the overall question, they would say, "No, I
do not support any of these approaches, because we
are still not guaranteed a better quality of life than
we currently have"

Mr Harrop: I would like to support what Andrew
has said, if I may? The critical issue that is missing
from this Green Paper is the analysis of the problems
of the current system, all those issues we talked
about at the beginning—about it not being available
to enough people and the amount spent per service
user being insufficient—all that is rolled forward into
the Green Paper’s proposals. The Green Paper is
mainly about extending the current offer to higher
income groups, rather than deciding: are there
enough services available, is the amount of resource
in that total envelope sufficient? We say it is not.
Where is that money going to come from? Is it going
to come from the individual? Is it going to come from
general taxation? is it going to come from a
hypothesised charge? But until you decide what is
the overall financial envelope that is needed for care,
you cannot really decide what funding mechanism
is best.

Q652 Jim Dowd: All Government money comes
from the individual, it is just a question of how.
Mr Harrop: In one way or another, indeed.
Jim Dowd: I am not trying to make up for lost time,
Chairman, so I will leave it there, I think.
Chairman: I am going to remind both witnesses and
questioners that we are just over halfway through a
session that should finish in about 13 minutes, so I
would like sharper questioning and sharper answers
if you do not mind, although obviously I do not
want anything not to be covered.

Q653 Dr Naysmith: I think this one should be rather
more quickly dealt with, because I think Mr Harrop
dealt with it just a few minutes ago, but just to make
absolutely certain, the Green Paper says that board
and lodging costs, sometimes called hotel costs, in
residential care should still be met by individuals,
supported by a means tested safety net, of course,
rather than being funded as part of a social care
package. You sort of disagreed with that, or do you
agree with it?
Mr Harrop: To be honest, it depends how much
resources are available from the public purse. People
do not choose to go into care homes, it is not like
going to a hotel, and their accommodation costs are
far greater than in their own home, I think in
principle, people would quite like to pool that risk of
having to pay those hotel costs. But frankly, it is
rather lower down the list of priorities than some of
the other calls on public spending, so it is back to the
question of how much money is available, and where
is it going to come from?

Q654 Dr Naysmith: So you would rather not answer
the question then really, is what you are saying? The
choice exists at the moment.
Mr Harrop: Our research suggests that people
with middle to high incomes would rather have most of
the costs of care, including accommodation, where
the risk is pooled, so you pay across society, rather
than pay individually. But that would be
expensive; we would need to get the political consent
to set up a new system which achieved that.
Mr Burke: It is also quite difficult to separate care
costs from all the accommodation or hotel costs,
however you want to describe them. I believe that
Donald Hirsch referred to having a kind of standard
accommodation charge, which may be a fairer way,
and certainly a more transparent way of doing it,
rather than each individual calculation being done
for every person.

Q655 Dr Naysmith: That was going to be my follow-
up question. Do you agree with that?
Mr Burke: I think that would be a much easier way
of doing it, if you are going to go down that route,
but we do need to remember, of course, that
accommodation costs will vary depending on
people’s conditions and so on.

Q656 Dr Naysmith: But you think that having this
levy on residents would be a better way of doing it,
and not trying to separate the two?
Mr Burke: Yes.
Mr Chidgey: All I was going to add is that I think
you need to think about what costs of
accommodation comprise. I think people think it is
perfectly fair to expect people to pay for things like
food, electricity, things that you would normally
have to pay for in your own home.

Q657 Dr Naysmith: That normally you would pay if
you were at home.
Mr Chidgey: Yes, but the fact that you may have
bought or been renting a home, depending on what
it is, and now you are having to go into a care home
because of your medical condition, is the rental charge and so on a fair thing to be asking people to pay?

Q658 Dr Naysmith: Sometimes you can ask for things like bigger rooms or single rooms, and that sort of thing would make it more complicated, would it not?

Mr Chidgey: Yes, it would.
Dr Naysmith: That was a good example.

Q659 Chairman: That was very good. I am going to disrupt it now by saying to Stephen: you talked about how the condition, in a sense, of an individual will mean the accommodation costs could be different; what about geography? Would accommodation costs be different in the middle of London as opposed to the middle of Northumberland?

Mr Burke: Yes, that is the other side of it.

Q660 Stephen Hesford: This is to everyone, but bearing in mind the Chairman’s injunction, I am not asking everything to dive in, but feel free: thinking of value for money for the public purse, might it be best to concentrate on small targeted changes to the existing system, for instance raising capital thresholds, increasing personal allowances for those in residential care?

Mr Burke: If I go first, I think what we have embarked upon is system wide reform and long-term reform, inevitably that will not happen for three or four years yet, so there are probably things that you could do in the short-term, so certainly increasing the capital limits, probably, I mean, £50,000 is a figure, but it is purely arbitrary, to be quite frank, but that was the figure recommended by a recent commission on care from Hampshire County Council as one measure. Secondly, looking at making the deferred payments scheme work properly and universally, so that people are not left to the whims of their local authority in relation to that. I think investing substantially, but we are not talking about huge amounts, in information and advice; so actually, if you helped people get through the system quickly and properly, then you save individually a lot of money, and you save the system a lot of time and resources as well. Then I think we need to look at things which we know that work, so around prevention, for example, investing in Telecare we know can save a huge amount for the system, and very quickly, as well as providing the kind of more basic support to people around helping around the home, gardening and shopping and all of those kind of things. The final thing, as I said, people’s homes are so important to them, they are fundamental to older people in particular, and if we were to invest a bit more in repairs, adaptations, home safety checks, and other support to people living in their own home, then actually, we would probably reduce the costs on the care system.

Mr Harrop: One of the really sad things about the Green Paper is it does not focus on housing as well. It is the classic silo thing; that Communities and Local Government issues have not really been focused on, so I would agree with Stephen there. On ‘tinkering’ versus ‘long-term reform’, the question is how much extra resource is available. I am sorry to keep coming back to this, but if you are only going to have an extra, say, £2 billion for the whole system, it is probably better to spend that money making the current system do what it is meant to do—rather than being incredibly rationed and inadequate by its own standards.

Mr Chidgey: The first choice would be quality; the second choice would be sort out who pays. I think you need quality first; tinkering is fine if it is part of an overall solution to move it in the right direction, but not on its own.

Q661 Sandra Gidley: We talked a little bit about personalisation earlier, but a question to all of you really: what do you think are the main benefits of personalisation of social care services, and what are the main risks?

Mr Harrop: Yes, the benefits are quite well rehearsed, in terms of much better choice for the individual, and the ability to wrap the service around your life, rather than it being delivered on someone else’s terms. The risks; to be honest, you could have an inquiry on this in its own right; there are significant risks about personal budgets. Firstly, it should not be just about giving cash, people should have the entitlement not to have the money and the management of it; someone else should tell them what resource is available and offer to spend it for them, and that is not necessarily always on offer, although it is meant to be. Market shaping is a massive concern; local government has to help the local providers through a major transition, rather than just leave them to their own devices. This is particularly true for group based services like extra care housing and day services, where economies of scale are a major issue; so if you have everyone as a personal budget user and one or two leave, the whole service could collapse. Risk is a major issue; are we letting down people in terms of safeguarding them from abuse, because of a more flexible service? And the burden placed on individuals and their families who do not want them—some love personal budgets, others do not want the extra hassle, so we must make sure that they do not have to take on the burden if they do not want to.

Q662 Sandra Gidley: Any disagreement with that?

Mr Burke: In terms of making personal budgets and personalisation work for older people, we need to ensure that people have not just real choice, and there is not real choice in a lot of areas, in terms of the kind of support that people can buy, but actually that people are given time to make decisions, they are not being rushed into things, which they are in many parts of the system at the moment. Also that people are given proper support: so real information, real advice, but also advocacy for people who need support to make their wishes known. But the other issue is about risk, and I think we have yet to have a proper debate in this country about where we are going in terms of risk, who carries the risk.
Mr Chidgey: I think there is a risk of an assumption that everyone is going to be able to do this, everyone is going to want to do this, when clearly, as you have described in previous evidence sessions, there is evidence that older people in particular do not necessarily want to take on this responsibility. Certainly some do, some need a lot of support to be able to do it.

Q663 Sandra Gidley: Why do not older people want to take on the responsibility? Personal budgets have worked very well for young adults.

Mr Harrop: One issue is that older people are very different, in terms of how they interact with the care system, because it is normally a time of crisis when you first need care, often on hospital discharge, and your needs change very, very frequently. So the model of having a fixed personal budget which you decide over a period of months or years how you are going to spend, does not necessarily fit with the reality of how older people’s lives work.

Q664 Sandra Gidley: Is there age discrimination in the way the budgets are being operated?

Mr Harrop: Yes, there is.

Mr Chidgey: I mean, the amounts, it is all about the amounts, and assumptions that are made again about what sort of support you might like to have. So although there are some very developed models for people with learning disabilities, for example, where large packages of support are being put in place, costing thousands of pounds a week, to help people to go and enjoy leisure activities, like going to a football match, as has been described previously, or whatever they might want to do, that is not really a reality when you are given a personal budget of £100, £150 or £200 a week, and actually the essential need you have is to get someone in to help you wash yourself, get up out of bed, have something to eat and get ready for the day. So there is no that budget left to be able to make lots of choices about things, so I think it is quite a different thing.

Q665 Dr Taylor: Should personal assistants be regulated, and if so, how? I am talking about the self-appointed, self-directed ones, because we were told by the Care Quality Commission that they would not have any role in regulating these sort of people. Who wants to start?

Mr Burke: You have had evidence from Unison already, and I think there is some merit in looking at how personal assistants are represented, trained, developed and supported. It could be through a trade union or perhaps a professional association, as we saw, for instance, with the growth of childminding. We had the development of the National Childminding Association, so why can we not have something similar. You could look at local authorities using, for instance, their trading standards function to provide some sort of accreditation. Some people do want reassurance about the support services they are buying. Some local authorities are now accrediting a whole range of practical support to individuals and so there may be scope to do that altogether. There are other people saying, “I want to employ whoever I want to employ” who want to take the risks themselves.

Q666 Dr Taylor: There would be an argument for local authorities buying banks of people.

Mr Burke: Yes, if that makes it easier to access personal support.

Q667 Dr Naysmith: Advocacy, advice and maybe even brokerage are essential to help people put together sensible care packages. Who should provide that and how should it be paid for?

Mr Chidgey: If you take information and advice, I think there is a significant benefit to having independent providers. We see that people want the assurance that they are getting some independent thought about what might be appropriate for them to help them make choices. I would say, would I not, that the voluntary sector is quite involved in doing that work and in many areas has quite a good record of doing it.

Q668 Dr Naysmith: Is that sufficient to have the voluntary sector doing it?

Mr Chidgey: I do not think there is enough by any means by way of information and advice. The risk of personalisation is that we do not provide adequate information and advice alongside personal budgets, which is one of the reasons why I think lots of people are not taking it up. In some cases we are being told, “You can take advantage of this,” but there is not necessarily the information about how it might work or what you might be able to access.

Q669 Dr Naysmith: Should local authorities take a more responsible role in this?

Mr Chidgey: Local authorities do not necessarily need to provide it themselves, but they should make sure that it is available if they are going to really develop the local market of services.

Mr Burke: Local authorities have to have a strategy in place by next April—

Q670 Dr Naysmith: I will come to you in a moment. Should there be any restrictions on what Direct Payment should be spent on?

Mr Chidgey: It would be a mistake to issue an edict that says, “There is a specific list of things that you can never spend anything on,” because there are some very good examples of people choosing things that a community or a local authority might not necessarily see as appropriate.

Q671 Dr Naysmith: I am sorry, Mr Burke, I interrupted you.

Mr Burke: Local authorities have to have a strategy in place by next April for the provision of universal information and advice in their area. The question is how they commission it. I agree with Andrew, in the sense that they need to commission some local provision—people who have local knowledge and can provide face-to-face support, whether it is advocacy or advice—but some of it can be
commissioned from national organisations who provide generic and specialist support. Counsel and Care, Age Concern and the Alzheimer’s Society all do that. You raise an interesting issue about audit trails in terms of spending public money. One model worth looking at is the Kent Card, run by Kent County Council, which enables people to spend their Direct Payments using a Visa card, so that at the end of every month there is a very clear statement of where that money has gone, but it is not about stopping people spending it on particular activities.

Q673 Dr Stoate: What is the role of prevention in assessments and support for service users. councils must not wash their hands of appropriate providers to use your budget is fantastic, but discharge that. Support from a whole diversity of statutory responsibility for local authorities to retain its core role in assessment because it is a would like to make is that local government must comfortable they feel about di...virus. It is for politicians to decide how political risk here. It is for politicians to decide how

Q672 Dr Naysmith: Do you have anything to add? Mr Harrop: To be honest, there is an issue of political risk here. It is for politicians to decide how comfortable they feel about different uses of public resources. On the issue of brokerage, one point I would like to make is that local government must retain its core role in assessment because it is a statutory responsibility for local authorities to discharge that. Support from a whole diversity of providers to use your budget is fantastic, but councils must not wash their hands of appropriate assessments and support for service users.

Q673 Dr Stoate: What is the role of prevention in social care? Mr Chidgey: The role of social care is to make sure that people with dementia, for example, can stay longer in their own homes; that they have access to communities. There is a great deal of evidence about the need for people to have social interaction with others and maintain peer support networks, to get advice from each other about how to cope and live more independently. That is one of the big things that social care can help to facilitate.

Q674 Dr Stoate: Yes, we would all agree that we do not want to cut corners, and prevention is obviously a good thing, but how are we going to square that with the fact that we are only talking about people with critical needs? Mr Harrop: One of the problems—and Andrew said it right at the beginning—is the difference between great policy rhetoric and the reality of delivery in a very tightly rationed service. The Putting People First agenda and the National Care Service concept both talk about prevention as part of that core offer—something different from the statutory entitlements (critical needs, et cetera) for people earlier on. The challenge is how you find the resources to pay for both. We need to think about this from the perspective of the whole public service economy. It is not just about social care departments. Critically it includes the NHS, because it gets an awful lot of the benefits from both primary and secondary prevention. But I would also focus on social opportunities and overcoming isolation in the round. Part of this should be the work of the National Care Service, or whatever emerges, but a lot more of it needs to be about all the public services—working with charities and businesses as well—thinking: does this community work for isolated and vulnerable people?

Q675 Dr Stoate: But the question still remains: How are we going to square the circle here? If we are really saying that social care in the home is only for people with critical needs, how do we bring in an element of prevention? Mr Burke: I think Andrew is right, though, it is about looking across the board. It is about government joining up. We have had the Strategy for an Ageing Society which really focuses on supporting active ageing and helping people to work longer and to make the most of later life opportunities. That is a critical part of prevention. We have the Lifetime Homes, Lifetime Neighbourhood Strategy, and, as I said earlier, housing and people’s homes, particularly for older people, are really important. If we make sure those are the best possible and make sure their local neighbourhoods are also very supportive, then that will work as well. We also need to invest in things like Telecare, because for every pound spent on Telecare you are going to save at least £5, if not more, in terms of other services for people with the highest needs.

Q676 Dr Stoate: We are talking about trying to advise government on how they should adopt policy. What levers would you want to see pulled to make that happen? Mr Burke: This is why issues about an ageing population and care need to be a strategic priority across the whole of a local strategic partnership, not just the issue of an adult social care department within a local authority, so that you take on board the other partners who are critical to making this happen.

Q677 Dr Stoate: What would the message to government be in terms of trying to set up a social care policy for people in older life? Mr Burke: We have got lots of policies; it is about making it happen in reality. The Strategy for an Ageing Society.

Q678 Dr Stoate: That is my question: How are we going to make it happen? Mr Chidgey: We have been trying for many years to make sure that it happens, but it has not happened. With evidence to support early intervention developing fast, but still not making sure investment happens, with continued leadership to tell people that it needs to happen, but it not happening, we need to have some enforced requirements and systems and budgets for early intervention and prevention services that make sure that that investment does happen. Inevitably, if you are in a local authority and your budget is going down but the needs are going up, you are going to have to focus on those people with the greatest need, but we need some requirements and we also need some recognition that the funding just is not going to do it.

Q679 Dr Stoate: All of you are calling for more money. We cannot simply go on calling for more money because that does not get us anywhere. Mr Chidgey: I am afraid that is one of the answers that has not been—
Q680 Dr Stoate: Whatever government forms the government after the next election, we cannot just magic more money. What I am saying to you is: How do we advise government on what to do with the money we have, rather than pretending there is loads more which is not there?

Mr Harrop: If you could do one thing, it would be to force the NHS and local government into joint commissioning. The benefits of the interventions flow to the NHS. It is the one that needs to be spending more money, in a strategic way, to meet its own objectives, through these sorts of community services rather than traditional medicine.

Q681 Jim Dowd: Do you mean extending it? Because joint commissioning already exists.

Mr Harrop: It is a bit optional at the moment. It is encouraged but it is certainly not the norm in every area of the country.

Mr Chidgey: You should push harder on getting people out of hospitals. I know that has been the direction for a long time but there are still huge amounts of people going in unnecessarily and staying a long time.

Q682 Chairman: Mr Burke, you mentioned technology and Telecare in particular. Telehealth, as well, would be a way.

Mr Burke: Again, that is an example of joint commissioning care.

Chairman: I would like to thank all three of you very much indeed for coming along and helping us with this inquiry this morning.

Witnesses: Mr David Congdon, Head of Campaigns and Policy, Mencap, Ms Sophie Corlett, Director of External Relations, Mind, Mr Stuart Nixon, Vice Chair of the Board of Trustees, Multiple Sclerosis Society, and Ms Imelda Redmond, Chief Executive, Carers UK, gave evidence.

Q683 Chairman: Could I welcome you all to our second session in what is our fifth evidence session on our inquiry into social care. Could I ask you, for the record, to introduce yourselves and tell us the current position that you hold.

Mr Nixon: I am Stuart Nixon. I am a trustee of the MS Society and a volunteer.

Mr Congdon: David Congdon, Head of Campaigns and Policy at Mencap.

Ms Corlett: Sophie Corlett, Director of External Relations at Mind.

Ms Redmond: Imelda Redmond, Chief Executive of Carers UK.

Q684 Chairman: I am going to start with the same question that I asked at the beginning of the last session. What do you see are the greatest shortcomings in current social care provision that can be addressed by national reform?

Ms Redmond: From a carer’s perspective, the greatest shortcoming of our current system is that it only deals with a tiny minority of people who need care through the Fair Access to Care system that we have. Only people who are at the highest level of care get any support from the local authority; the rest are left on their own with their families. The needs do not go away, and so, therefore, families and carers step in. The support for carers and families is simply not adequate and the benefit system that is supposed to be there to support them is also inadequate. There is not enough quantity in the system.

Ms Corlett: Access to care: about 7% of the social care budget goes on people with mental health problems, although obviously they are a huge group. There are quite a number of barriers, including expectations that they do not need social care. Getting into the system; it is only accessible at the point of crisis generally or when people are really very unwell. Prevention is not something that social care is really contributing to at the moment. A big divide between health and social care: people are not getting things through health but they cannot get them through social care. The one is not working with the other really to support that, which means that people often are not getting support that works in a positive way to empower them, so they are getting things that are given to them rather than things that help them do things—if you can see that distinction.

Mr Congdon: I have very similar views really. The tightening eligibility criteria made it much more difficult for people with moderate needs to get social care—indeed, people with a learning disability, most with mild and moderate learning disabilities, do not get any support at all—coupled with the postcode lottery. People feel they always have to fight to get services. Those are the main things: the postcode lottery and the tightening eligibility of material.

Mr Nixon: My views would echo those already said. The only thing I would add is that services which promote inclusion of disabled people, particularly younger disabled people, in society and offer them not just choice but control over what they need to support their lives and a system which promotes aspiration.

Q685 Chairman: We will pick up. I am sure, on one or two of those issues. Are shortcomings down to overall funding levels or the particular way social care is funded? You have mentioned, Sophie, the means and eligibility criteria as well, which I think we are all familiar with, but is the problem with it that we have means testing and we have this wide variation that has just been mentioned as well?

Mr Congdon: Generally the problem that the social care system faces is that there is a growing demand for it. You have heard before about the growing demands in terms of older people. The demographics are very significant. They are also significant in the field of learning disability, for instance. A growth of 3% to 5% per annum is predicted by Eric Emerson of the University of
Lancaster. Local authorities are struggling to meet that growing demand with limited funding to achieve it. That causes all sorts of stresses and strains on the system which means that very often they do not necessarily purchase care in the best possible way. The classic example would be that, late on a Friday afternoon, they get a call of someone in crisis, needing to provide something for them; they then ring around all over the country to try to find a place and often will find some home miles away from where the person lives—it could be 200 miles or more away—those places will be very, very costly, they have not been planned, and then what often happens is that person will get trapped in that particular care situation for 20 or 30 years. The problem is, with a system under growing financial pressure, that planning does not take place early enough. That is a particular issue at transition for people coming through the education system and then needing to access adult services. That is one of the key problems: they are struggling to cope with a growing demand and limited money. That is not to say that significant amounts of extra money have not gone in. The issue is the level of extra amounts relative to the demands that are being placed on the system.

**Ms Corlett:** I would want to add to that an understanding of what the overall pot is. A lot of the way that the money is spent is not the most efficient. You deal with people when they are in crisis and then you have quite strict eligibility rules, which means that they are not able to access funding until they are in crisis, which can bring on a crisis, and it will cost you all. It is more about the eligibility than it is strictly about the funding.

**Q686 Chairman:** Do any of your organisations have any measurement of unmet need in social care? This is a question we are asking all witnesses, and we are not getting quite specific answers.

**Ms Corlett:** Not quantifiable. Vast numbers of people tell us they do not, but we have not surveyed the one in four people in the population with mental health problems.

**Ms Redmond:** We know the number of people who are providing care, family carers. We know that there are 2.5 million doing 20 hours a week or more, and we know that there are between 1.7 million and 2 million people receiving social services support across all age groups. You can see a gap there and some of those will be counted in that other number, because they are getting some support, so there is quite a bit gap there.

**Mr Congdon:** It is quite difficult to measure unmet need. I mentioned people with mild and moderate learning disabilities, but those with the greater needs will be getting the level of support but they may not be getting sufficient support. That is very hard to measure. The best example I would give, which echoes really the point that Ms Redmond made, is in relation to breaks for carers. We have done two reports over recent years, both of which were quite, not very creatively using the same name twice, **Breaking Point** which was about carers having been parents of people with learning disabilities, having been at or nearly reached the issue where they are literally at breaking point. Staggeringly eight out of ten in one survey and seven out of ten in another were prepared to admit they were at breaking point, which is quite brave to admit it, literally wanting to give up and whatever. That is not a bad measure of the unmet need in terms of breaks for parents of people with a learning disability.

**Mr Nixon:** One of the things that we get consistently when we survey our community with MS is the issue of variable condition. MS is such a variable condition that people fall through the cracks: they may, for large periods of a year, be quite comfortable and have no problems and be doing all right, but then they get a relapse, and what happens is that in no way can social services or social care do the support that respond to their needs in that situation. It might only be for a two-month period, a month period, even a couple of weeks, but they need that support that because no proactive planning was put in place and no support was there in a proactive, planned way, no response can happen in that limited period, and that has an enormous effect on our community.

**Q687 Charlotte Atkins:** Ms Corlett, you have mentioned already issues around mental health, but in your submission you suggest that people with mental health problems do not fit easily into health and social care boxes. Why is that and how can it be addressed? I assume it is not being addressed in the Green Paper adequately.

**Ms Corlett:** The why is tied up a lot with people’s understanding of mental health, what it is and how you recover, and so I will set that to one side and deal with the detail of what that is. For a lot of people, what they need from social care is to be expert that you can divide them, is not that something be done for them, but that someone does things with them, so not that someone comes around and gives them a meal but that someone comes around and helps them to shop and to cook and gets them back confidence to do that or to go outside. Those things support your clinical symptom reduction, but it is not something that health is going to fund. Health will look at your clinical symptoms and look only at what are considered to be health interventions, which might be drugs, which might be talking therapies, which increasingly now might be slightly wider things, like exercise. Gaining back your mental health is a lot about gaining back your wider life and that is where social care can come in, but these things overlap massively. The impact of a talking therapy or of doing some exercise or of someone going shopping with you can be the same in terms of your improvement and your general wellbeing, so they are very difficult to unpick. I do not think what happens when people are assessed in either system is that these things are necessarily taken into account, and so often, when people have their care programme assessment done within health, the social care section is just left blank, the person assumes that they are not going to get social care because they can still cook. Even though they are not cooking, they can still cook, so that is not something for them. Likewise, if the person comes into the social care system assumptions again are
made about the individual and what is necessary for them. One feeds the other, and for the opposite reason than the reality, which is that many of these things ought to be supporting each other and together helping somebody to get better.

**Q688 Charlotte Atkins:** There needs to be a more holistic approach to the individuals.**Ms Corlett:** There needs to be a more holistic approach to join it up with some other things, like employment and housing. Poor housing has a massive impact on mental health problems, as does employment or lack of, so it is much wider than just health and social care both in terms of improving someone’s social situation but also improving their mental health symptoms.

**Q689 Dr Taylor:** I want to come back to your point about the variable condition and the difficulties that produces. In your submission you have some examples of where this is being tackled. Flexibility is vital. You have an example from East Sussex. Can you expand on the ways in which the variability and difficulties are being tackled. Flexibility is something that we would recognise as a useful addition and a useful step forward.

**Mr Nixon:** Our feeling is that there is still more work to do there. There is clarity that needs to be able to be brought forward in that area, but the draft is something that we would recognise as a useful addition and a useful step forward.

**Q692 Dr Stoate:** I am going to try again with my prevention question. Ms Corlett has already alluded to the fact that prevention is a really good way forward. How can prevention fit into a social care policy that works in real terms?**Ms Corlett:** With mental health it is a very fluctuating condition. Unlike learning disabilities, it is something that you can recover from. Maybe you do not lose your symptoms but you can recover back your life to quite a significant degree and then you might have periods when you are less well. If you can invest in people staying well or having fewer and less severe episodes of poor health, that is obviously a good investment.

**Q693 Dr Stoate:** I understand all that. That is self evident. Clearly as a doctor it is obvious that prevention is better than cure. There is no argument there. The question comes in what you mentioned earlier. If you only access services at the very highest level, the critical needs level, how does that square with informing government policy on how to move forward. What should we be advising government to do in terms of squaring this circle between pairing the available to people with critical needs and yet prevention being the way to avoid that. How do we do that?

**Ms Corlett:** Lower the threshold.

**Q694 Dr Stoate:** If we lower the threshold, we simply put the costs up. In real terms, is there not that much more money around.**Ms Corlett:** I do not think you do put the costs up. I think you reduce the costs significantly. I am not talking for any other group. I do not know whether this model would work in other cases, but in mental health, if you lower the threshold, you put services in earlier, often at quite a low level type (buddying support, befriending, things that can give people motivation—and they do not necessarily need it all the time but they can have access to it), you not only save on social care, you save on health, you save on unemployment benefits.

**Q695 Dr Stoate:** Is there any evidence to back that up?

**Ms Corlett:** Yes, there is evidence to back that up.

**Q696 Dr Stoate:** Is there any evidence for any of the others that a similar approach might work?**Mr Nixon:** We can offer exactly the same sort of situation. If you help people stay in work, stay actively part of a community, they will benefit significantly when living with a condition like MS. We know that anxiety, stress, issues associated with worklessness have an impact on people’s progression with MS. If we can maintain them in part of a community, part of society, working, in family life, their progression will be affected. That, as
Q697 Dr Stoate: Are we saying that the Government is all completely wrong and focusing only on critical care is totally the wrong thing to do? Is that what we are saying?

Mr Nixon: It has an enormous impact on the people who I represent, in that by not supporting them at a lower level, you increase the pressures on them when they are living and trying to maintain positively in society, and the results of that are often worsening of the condition.

Q698 Dr Stoate: What I do not want to hear is that it will only get much better if we had vast amounts more money, because that is not the real world. The real world is that I want to see if we can improve the situation by preventative means without simply saying that what we need is vast extra resources.

Ms Redmond: What you are asking is absolutely right and I do not think we have nearly enough evidence. You are not going to prevent people becoming critically ill if they are on that pathway. That is not going to happen. It is bandied around without enough evidence. This is not a prevention question, it is more the focus on critical being wrong. I see it as wrong because the people who are the level down from that still have high levels of need and that care still has to take place. As an example, one of our members who has three children with moderate learning difficulties and they get nothing in the family because all three of them have moderate learning difficulties. People do not step back and see the context. They cannot roll it up into critical, if you like.

Q699 Dr Stoate: I understand that, but that is not my question. My question really is about whether we need to focus more on prevention as a way of managing a very difficult situation.

Ms Redmond: The new bill that was published yesterday does talk about rehabilitation. Maybe we will get some good research coming from that, if you focus in on rehabilitation first and then move to your long term care. I do not think there is enough evidence.

Q700 Dr Stoate: That is what I am asking.

Ms Corlett: I think in mental health there is.

Q701 Dr Stoate: I am interested to hear that.

Mr Congdon: I would echo the lack of evidence and make the point that 40% of people with a learning disability suffer from mental health problems. It is one of the reasons why we support the move towards encouraging more people and enabling more people with a learning disability to work, because very few get the opportunity to work. Intuitively it is right, as you said, that prevention ought to be better. It ought to be cost-beneficial. It is quite hard to trap all those costs. Some of the costs might not actually be trappable (if that is a word). It may simply be enormous responsibility is put on family to support their sons and daughters which creates enormous stresses for them. That is what tends to happen and then services only come in when there is a crisis. That is really the challenge. I do not think there is any easy answer for that. If you could manage to trap where those other costs are occurred, that would help, but some of them will not be visible on the balance sheet.

Dr Stoate: Thank you.

Chairman: I thought I read a few weeks ago that the Government were putting some sort of talking therapists into the National Health Service, but they were described as marriage guidance counsellors in a tabloid that I read. I thought that they were looking at doing these wider issues, as it were, with people in the health scenario anyway.

Q702 Stephen Hesford: How prevalent is poor social care? Can anyone give specific examples of where the system really does fall down?

Ms Redmond: Some of the descriptions that you had in the session before are absolutely accurate: the 15-minute slot, the very poor assessments, the change of care assistants going in the house so there is no consistency, the real pressure between continuing care with the NHS funding and social care, where people are trying to say, “You’re not my patient.” That is absolutely terrible. The sheer quantity of it is not good enough. The move towards personalisation is an improvement for the people who are getting it, so you are seeing fewer people getting a better service but more people being kept out of it. In a lot of places it is very poor. Some people are getting a very good service. A few people are getting a very good service.

Mr Congdon: We would probably say it is less of about poor care and it is more about no care at all or inadequate levels of care. Everywhere where we do get examples of poor care, which are very disconcerting, are those with the most complex, profoundest learning disabilities, who will often have health needs as well. They do need staff with more specialist skills; they need to understand their behaviour problems. There is a tendency, if you have staff with lower levels of skills, to rely on drugs to sedate people, which then has its own implications and you then get trapped into long-term high costs, which I was mentioning earlier, so there is some evidence, particularly at that end, of the inadequate levels of care. We have examples of people, for instance, with profound disabilities going to a respite care centre at the weekend and coming back with sores on their body because they have not been properly looked after. There are issues like that. I would not want to create the impression that that is general amongst the care of people with a learning disability, however. Usually it is either, as I say, no care or inadequate levels of support.

Mr Nixon: I would echo the points that have already been made there. One of the things that our constituency tell us more than anything else is that it is a lack of specialist knowledge, it is a lack of knowledge around the condition, which causes considerable difficulties. People living with MS certainly have very specific, very particular needs and requirements and they are often not met because
people are not trained to a specific level. The other issue is the continuity of care, people who have quite specific needs need to build a relationship with the people with whom they are working, and, unfortunately, often working with agencies and directly delivered care that does not happen. It is John on a Monday, Freda on a Tuesday, these people can change day in, day out, and so you are over and over again having to explain, “This is what I need. These are my requirements. These are the issues that I face.”

Q703 Stephen Hesford: You can break it down into component bits that do not work. Do you want to say anything on underfunding?

Ms Redmond: There is gross underfunding in the system. There simply is not enough money in the system. We have talked a lot about people at critical level only accessing services in a lot of places. As I have said, there is all this unmet need, there is not enough money, and that is why people are getting these 15-minute slots, in/out, because that is all that can be afforded within that package. It is about just keeping them alive really.

Q704 Stephen Hesford: What about in the private sector? Are there training issues?

Ms Redmond: It is the same. They are regulated in the same way. In the public and private and voluntary sectors, care standards are the same.

Q705 Stephen Hesford: There is not a qualitative difference between public and private.

Ms Redmond: It is about how it is commissioned really.

Mr Nixon: Ms Redmond has talked about the 15-minute time slot. Fifteen minutes is fine for a non-disabled person to wash their hands and face and get themselves sorted out, but the issues are that when you then have someone with a disability who has a complex set of needs, they might need to move slowly, they might need to be encouraged and supported during what they are doing, 15 minutes is a nonsense. It is a 45-minute issue to get somebody out of bed and get somebody sorted out in the morning.

Q706 Stephen Hesford: Is social care the Cinderella service or is it better than that?

Ms Redmond: Cinderella service within public services?

Q707 Stephen Hesford: Globally.

Ms Redmond: Yes, it is. It is not understood. Understandably it is not understood because it is so complex. Even as you look along this line here we are talking about adults with a health condition, we are talking about mental health, we are talking about an ageing population and children with disabilities. When we had the huge growth in welfare reform and the growth of the NHS, it was not part of it because our systems were so different. It has grown up in this very odd way, and, yes, it is the Cinderella service, because it is about people in difficulties rather than your total community. It is about crisis intervention, on the whole.

Stephen Hesford: I see other people nodding. I will leave it there, thank you, Chairman.

Q708 Dr Naysmith: Ms Redmond and Ms Corlett have both mentioned these 15-minute slots in this session, and we have been hearing a lot about them with other people giving evidence. How widespread are 15-minute slots in the service? Is this something that has been increasing a lot recently?

Ms Redmond: From our experience and certainly from what our members tell us it is pretty widespread. An elderly person who has had a stroke, come out of hospital, will be getting these very short slots a couple of times a day. Is it getting worse? I have been hearing complaints about the 15-minute slots for a long time.

Q709 Dr Naysmith: A couple of years or longer?

Ms Redmond: Longer.

Q710 Dr Naysmith: As I understood it, social workers used to be given a workload for the day, and they would go, and maybe if somebody needed a little bit longer, they would stay a bit longer. Obviously it was sorted out in terms of a timesheet but there was a flexibility that seems to have gone. Is that right?

Ms Redmond: That is what families tell us, that the way things are commissioned now it is about really driving down the costs, so you have people on minimum wage. As a provider, if you can drive down your costs, you are more likely to clean up on contracts. That is what it is about. It is about those contracts delivering as cheaply as possible.

Q711 Dr Naysmith: Do you agree with that?

Mr Nixon: I do. I think you need to take a pace back and look at the definitions of what is going on here. We have critical and substantial being the only two levels of care that are being met. The very fact that you have somebody with critical or substantial needs means they are going to be complex, they are not going to have things that are straightforward. You cannot do something that is not straightforward in 15 minutes.

Q712 Jim Dowd: Cinderella service—I am never quite sure what that means generally, because local authorities were making provision in this area for many, many years before there was a welfare state or a National Health Service. Is it not the fact that the problem is larger than the resources available to deal with it?

Ms Redmond: It is a factor that there is not enough resources to deal with it. The policy and the direction of travel, the language of social care, is something that many of our organisations would really sign up to. The Putting People First, the carer strategy, is all in the right direction. There is not enough resource in the system to deal with need.
Mr Nixon: This is one of the things that I would raise a deal of issue with. I appreciate what Ms Redmond says, there is without doubt a practical age discrimination going on here, but in fact a benefit of that does not necessarily compute directly for working age people, because directly supported care is not responsive to people who want to work, it is not responsive to those who want to maintain their lives as part of a community. This is one of the drives for personalisation that we see as an organisation. We need to have more control so that we can put in place, be it Direct Payments, be it personal budgets, that will allow that flexibility that then allows someone of working age to work. We do not get that sort of flexibility with a directly funded package.

Q717 Jim Dowd: How do you deal with the difficulty of people with disability-related benefit, disability benefit itself or DLA? If you assume that this is not necessarily for life, when many of them assume that it is, if you suggest the idea that this is an enabling process so that they can go back and become independent, it is a threat to their standard of living. They do regard themselves as permanently in that condition.

Mr Nixon: We within the MS Society would like to see an approach to care services, be they social care or beyond social care, which promote the inclusion of disabled people in society so that we can live as active partners. Without doing that, you create the dependency culture, where everybody sitting in a
I agree completely with that.

Mr Nixon: to a very minimalist service which would be a very learning disability get the opportunity to work, but if cheap. Sadly, at the moment very few people with a enabled to live like equal citizens. It is a really when what most of us are talking about in terms of morning, to go to bed at night, to be fed and watered, basic care, just enabling people to get up in the

Mr Congdon: I would like to echo all of that. The policy framework for social care, whichever document one refers to, the original Green Paper a few years ago on adult social care, the White Paper: Our Health, Our Care. Putting People First, a whole plethora of documents outlining an approach where people are enabled to live like equal citizens regardless of their degree of disability. That will cost money to do so. One of the concerns is in the medium term is if some of the statements in the latest Green Paper are not fleshed out a bit, such as what does “basic care” mean. Basic care could mean very basic care, just enabling people to get up in the morning, to go to bed at night, to be fed and watered, when what most of us are talking about in terms of provision for the social care system is people being enabled to live like equal citizens. It is a really fundamental point. Of course that does not come cheap. Sadly, at the moment very few people with a learning disability get the opportunity to work, but if they did they would get the opportunity to pay back some money. That is part of the vision, not regressing to a very minimalistic service which would be a very retrograde step.

Mr Nixon: I agree completely with that.

Q718 Chairman: Could I take you upon that point. A number of years ago now, people with learning disabilities used to be able to go to further education colleges beyond the age of 26. Beyond the age of 26 they are not allowed to go to FE colleges now, unless they are on designated courses. What is Mencap’s view about changes like that?

Mr Congdon: We have seen over the last ten years or slightly longer, more people going to further education colleges but then more recently, partly because of changes in funding and partly because of unintended consequences of other policies, we have seen courses for those who are doing courses that do not lead to recognised qualifications missing out. The difficulty in going much further in answering a question on that is the evidence from the Learning and Skills Council groups together people with both a learning difficulty and a learning disability—and they are quite different as a group of people. Certainly the evidence from survey work we have done is that courses for people with a learning disability have certainly been cut, partly because of changes in the way that funding has been set up. The difficulty disentangling it is that some of the courses people have been on have been very poor, and people have gone round the revolving door of course after course after course, the same course, not leading to anything, and that is not terribly desirable. We wish to see people with a learning disability have opportunities to access further education and education of various types, to enable them again to fulfil the role of being an equal citizen. It is part of that package. The policy context is seen a move away from large institutional day centres that years ago used to do work-related activities and became much more education biased, which has been a good thing—to more outreach activities—which is again a good thing—but it is dependent on a number of things. It is dependent on having more job opportunities and also dependent on having more further education opportunities and there are issues there about ensuring in the current changes that are going on of moving a lot of the funding back to local authorities, which on the one hand could be an advantage leading to more joined-up provision for people with a learning disability, but on the other hand it could lead to some of the funding getting dissipated, so there are some concerns around further education provision.

Q719 Chairman: My local authority organise two areas where people can work. One is grass cutting in the summer, if they are physically capable of being able to go grass cutting. The other is print workshops, where people can go and work for a day. I think the income is £20 and it does not a workshops, where people can go and work for a day. I think the income is £20 and it does not affecting wider quality of life issues for these

Mr Congdon: We would rather see more, if I can use the word, “mainstream” job opportunities. One of the problems with anything which is on some sort of sheltered basis is that people would go to a workshop—and some people used to go to workshops five days a week—and whereas the theory was that they would then move away from that into mainstream employment, the reality was that very few did. Part of this is trying to get out of the situation where all that people with a learning disability get is work experience after work experience after work experience and not being paid, and wanting to get people into genuine paid jobs and ideally into situations where they are working full time—or certainly at least 16 hours a week or more—because that makes a major shift in their ability to participate in society.

Q720 Dr Taylor: Can I ask each of you for a brief initial reaction to the policy of providing free personal care at home for those in greatest need. We have only just today had this document, so no detail, just a brief initial reaction.

Mr Nixon: Some of the issues are around the tightening and narrowing of the brackets of eligibility for this care. We really see that, potentially, at the moment we have a very narrow bracket as it is, and if we are moving down this road it is only
likely to get tighter and so the number of people excluded from some care is likely to go up. That for our constituency is an enormous issue.

Mr Congdon: The general concern we would have from a learning disability point of view is that although the funding is available for anyone over the age of 18, as I understand it having briefly looked at the document, in practice most people with a learning disability would not in fact pay because of the way the rules work. That is good on the one hand, but the concern is much broader than that. The £250 million that has to be paid for by local authorities is inevitably going to lead to even more pressure on what we were talking about already as that pressure, and the only way that local authorities would be able to square that circle would be to tighten their eligibility criteria. That is the fundamental concern. They have to find that £250 million amongst all their other efficiencies they are trying to achieve.

Q721 Dr Taylor: Really the same view about eligibility.

Mr Congdon: Yes.

Ms Corlett: We have not looked at it from Mind’s point of view at all. I am thinking that for people who are in the critical stage and are needing that level of care, then home is probably somewhere they would be getting health services rather than care services, so it gets complicated by this health/social care divide again.

Ms Redmond: We welcomed it because we know that many families are in the situation of somebody who is at critical level of need—I think there are four levels of ADLs—and they are really struggling. They are really struggling with the costs of that care and so we welcome it. Anything that helps families, we really welcome. We really like the idea that you have the first period of that time, which is about rehabilitation and proper assessment, to see what the ongoing needs will be and whether other interventions can come in to assist the family and reduce the costs—like, for example, Telecare coming in or some sorts of therapies going in—and give somebody back more of their independence. Currently people at that level of need are discharged from hospital, and they either have to set up their own package, because the local authority has said they have too much assets, or they are put on the 15-minute slot thing. The idea of the rehabilitation and guaranteed care will take a huge worry from the families who are in that situation.

Q722 Dr Taylor: Can you see any unintended consequences of perverse incentives?

Mr Congdon: Yes, and our colleagues earlier today talked about it. But you have that with most policy, do you not? This is about free care in the home. What is the incentive? An older person who has been very frugal all their lives finds it incredibly difficult to start spending out £200 or £300 a week on their own care. They might say, “No, no, no, I’m not going into a care home because I will have to pay £800”—

Ms Redmond: It might be the best place, but they might be saying, “No, I’m not prepared to pay £800 a week for that.” You can see it. Likewise, the local authority might be saying, “You get into a care home.”

Q724 Jim Dowd: I want to look briefly at technological breakthroughs. There was a recent report of attempts to find a drug therapy for Down’s syndrome. How likely is that kind of scientific advance, and what effect will it have for the need for social care?

Mr Congdon: As I understand it, it is too early to judge whether the Down’s syndrome bit of research will lead to anything significant or not. On a broader point, it is unlikely—but one can never predict the future—that there are medical solutions of any shape or form to learning disability as a generality and, therefore, the idea that advances in medical science of any shape or form or genetics will lead to a significant reduction in the demands in terms of social care for people with a learning disability I do not think are valid, to be perfectly frank.

Q725 Jim Dowd: One of the previous witnesses, who was from the Alzheimer’s Society, said there was nothing on the horizon and it would be 15 years and maybe longer before anything even changes. Is that true for MS, Mr Nixon?

Mr Congdon: The impact on the pressure for social care will be minimal.

Mr Nixon: Yes. We do not see it having an enormous effect.

Q726 Dr Naysmith: All of you have spoken this morning about how it is important for the various client groups that you represent to get into work if possible as part of rehabilitation, yet the Green Paper has been criticised for failing to spell out clearly how the various future funding options for social care would affect working age people. Do you agree with that? Once you have answered that question, which of any of the funding options in the Green Paper do you favour and why?

Ms Corlett: We struggle to know how things would affect working age people, so we do agree with that assessment. We did quite a number of focus groups and work with people with mental health problems, a higher proportion of whom, over 70%, are likely to be dependent on welfare benefits, less likely to be
working, more likely to be on very low income and therefore to be in debt. We are concerned that they might need to find big amounts of money at some point or it would all be reliant on their assets after they died and then thinking, “What assets would those be then?” People do have those concerns and the funding option—

Q728 Dr Naysmith: Are they valid concerns?
Ms Corlett: They are valid concerns. Particularly if you are thinking about insurance, particularly private insurance, a premium might well consider those to be people at higher risk and, therefore, a higher premium, which would obviously be self-defeating.

Q729 Dr Naysmith: The insurance matter is particularly important for your group of people.
Ms Corlett: Yes. The general taxation, the fifth and ruled-out option, was the one that people overwhelmingly preferred.
Ms Redmond: The Green Paper was weak on working age. I do not think it was intended, but then people started looking at: How do you fund older care? One of the things I want to make sure we do not forget about is that 80% of carers are working age and they are mostly looking after older people, so any older people’s service that does not work right means that more and more carers fall out of work. At the moment it is around one in five people with caring responsibilities who are falling out of work. In terms of a model, it will not surprise you at all to know that when we went out to our membership they said taxation. That is partly for some of the reasons that Ms Corlett said: the people who would be in our membership are likely to be the people who are most hardest hit, so they are either on very low income part-time work or out of work completely, and so the idea of paying lump sums in large amount is just beyond their comprehension. They might have a house; they might be paying the interest on that house but not necessarily the capital. As an organisation, taking a different view, we do understand the need to bring more money into the system. The idea of lump sums at 65 did not resonate well, because it is an unimaginable sum for people who are earning £20,000–£25,000 a year, but some sort of inheritance tax death duty, when thrashed through with our policy people and our trustees, was more acceptable.
Mr Congdon: We struggled with the Green Paper as presented, because clearly, as presented, it did not really address the funding issues for younger age adults and it was quite an effort to crawl through the impact assessment and fully understand what it meant. We understand the modelling made the assumption that younger adults would not really be making any significant contribution to their care, and so in that sense it is helpful and the Government has confirmed that. There is a difficulty, of course, if other policies start to work well and we were in ten years’ time to have significant larger numbers people with a learning disability in work, for instance, then there would be issues around that. We struggle with that. Nine out of ten of our members, and we consulted widely, felt that—surprise, surprise—a tax-funded option would be the best, but if we had to go and vote for any one of the three in the Green Paper, then we would probably go for the comprehensive option, but we do not really think that is necessarily the best way forward.

Mr Nixon: MS starts to affect people between the ages of 20 and 40, so has a significant impact on their ability to accumulate wealth over a lifetime. As I have stated, the idea of a large lump sum on retirement just seems far and away from reality. In view of that, when we surveyed widely across the organisation, needless to say the tax-funded option was the preferred one. If we are going to do anything else, the only other area that our constituency talked about was the comprehensive funding option and we had about 28% acceptance that this was the way to go.

Q730 Dr Naysmith: A special question arising out of the Green Paper for Mr Nixon and Ms Corlett, both your organisations oppose the integration of disability benefits into social care funding. Would you explain why. Are you reassured by the Government’s clarification that Disability Living Allowance for people under 65 has been ruled out of any such reform?
Mr Nixon: From our perspective, the disability benefits are the original independent budgets, because they allow somebody with, at times, lesser needs to make up the shortfall because of the costs that they incur because of their disability. We have large numbers of testimonies about how people use their benefit to level that gap, be it through simple things like buying higher quality linen because they need to change their beds that much more often than anybody else does because of continence issues, through to financing complementary therapies, complementary treatments which are not available through the NHS, through to things that might on the face of it appear quite frivolous, in the way of having somebody paint our nails or wax your legs. Most ladies will do that themselves, but if you have a significant long-term condition and you cannot move around and you cannot do that, to have those things done for you really makes an enormous different to your feeling of self-worth. Those sorts of things allow people to actively make choices and live in the way that they want to, so any attempt to remove those sorts of supports for people living with long-term conditions, living with MS, would be anathema to us. That flexibility is all about the prevention. At times, when people have a relapse, if they do not happen to live in East Sussex or they are unfortunate enough not to live in East Sussex, they can pay somebody to come in in the morning and help them get out of bed during that two or three month period possibly when social services are not able to respond to their needs. They are very flexible benefits and they are the things which enable people to live with long-term issues.

Q731 Dr Naysmith: It has been suggested that such benefits can be very poorly targeted. The people who make that statement have an idea that there might be...
gains to be made from distributing this money and other funding streams differently, but presumably you will go along with that.

Mr Nixon: Our view on that would be very simple and straightforward: what makes this community different from the main society is that all of us have additional needs, additional costs that we incur because of our disability. It is not about whether or not you have an extra £10 in the bank; it is about the fact that your daily life costs you that much more to live.

Ms Corlett: They are covering different things. DLA is not about care; it is about the extra costs of living with a disability. Somebody with agoraphobia might be spending an extra £5 because they are shopping online and they are paying £5 for delivery or someone with OCD might be spending a lot more on cleaning material. Somebody I know is spending a lot more on cleaning materials because they are doing a lot more cleaning in the house. It is the principle of the thing. It serves a different purpose and it carries with it already that personalised independence that you can use it in your own way which hopefully Care will do later but it currently does not. The second thing is the number of people who are eligible. Just under three million people—2.87 million is the figure I have here—in the UK who receive Disability Living Allowance or Attendance Allowance are not eligible for social care services, so it is no good saying, “We’ll wrap it all up as one” because that leaves a whole bunch of people who are not going to get anything at all and they are the people for whom those small amounts of money are providing a preventative mechanism. They are using those to keep themselves well or to keep their lives turning over. It is a fairly small intervention, but it does affect the bottom line for society as well as for that individual in terms of how their lives turn around but also in terms of how the economy turns around. By all means target it better if that is a problem, but do not assume that you can wrap it up into one thing and that the eligibility system for that one thing will work for something which was set up to do something completely different.

Q732 Dr Naysmith: Ms Redmond, do you think there is a possible concern about possibly losing disability benefits that are “carer-blind”.

Ms Redmond: Absolutely. My postbag is full of letters from people saying, “Please don’t let this happen.” It is the only benefit that is carer-blind like that. The Green Paper does not intend to be carer-blind. It assumes that families are still going to carry the vast majority of work of caring for ill, disabled and frail people. The people are very anxious about the removal of Attendance Allowance and I can really understand why. As Ms Corlett said, many of the people who are getting Attendance Allowance are getting absolutely nothing else. They are not getting any help from anywhere else at all. It pays for the costs of disability: it pays for the cost of putting your washing machine on five times during the course of a day; it pays for the cost of having to get a taxi to go to your hospital appointments. It covers those sorts of things. I have heard the anecdotes, and I am afraid I have heard the anecdotes from people in the Department of Health about their own family not needing it. They are not the families I am dealing with. I am dealing with families who have been on low income most of their lives because of sickness and disability.
will want to have the money. They might want it personalised but not to take the money; other people might not want it personalised at all. We need to leave those options open, but we need to be able to encourage people towards taking the steps to say what will work for them rather than receiving a system. Going back to one of the earlier questions: What does poor service look like? Poor services can go on holiday, which at the end of the day was well publicised in buying a season ticket for his carer to go to the football. The media headline of that is potentially quite damaging, but Gavin recognised that respite care for him and his wife was about her having half a day a fortnight to go off and be able to do exactly what she wanted to do while he was in a safe and managed environment, doing something he enjoyed doing as well. That sort of creativity is something that we have been championing, really, personalised budgets with individuals. It is not as difficult as it seems. Things around brokerage and around advocacy are the safeguards that you need to put at either end of it. Within that, people are very able to make decisions.

Q734 Dr Taylor: Do you have any ideas for how you would support people with mental illness to be able to take these decisions and to control their personalised care?

Ms Corlett: Yes, we have been doing a project that the Department of Health funded called Putting us First, where we have been supporting individuals, where we have been championing, really, personalised budgets with individuals. It is not as difficult as it seems. Things around brokerage and around advocacy are the safeguards that you need to put at either end of it. Within that, people are very able to make decisions.

Q735 Dr Taylor: Moving on to personal assistants: should they be regulated? If so, how?

Ms Corlett: There is no harm in having regulated personal assistants but that cannot be the be-all and the end-all. There are two problems with it, and they exist at either ends: the number of false positives and the number of false negatives. This was brought up by a lot of the people who came to our focus groups on this particular issue. A lot of people will benefit from peer support, from somebody who has been through the same as them, who has come out the other end, and who is currently well. Many of those people, when they have been unwell, will have come into difficulties with the criminal justice system. They might well not get through a CRB check and yet, actually, they are extremely able, and so there is a false negative there. A CRB check only counts obviously those people that have been caught and you then are not necessarily providing any safer system by running that. People were saying that it would be useful to have a pooled system, which would have the benefit of being regulated and also have the benefit of being there flexibly, that they could have access to.

Q736 Dr Taylor: By a pooled system, you mean a local authority holding sort of bank.
control. We have talked a lot about choice and control today and one of the positives I see with personalisation is that it is the opportunity to exercise control rather choice. Choice is something that we tend to offer: more often than not somebody says to you, “Would you like this or that?” That is not independence. Independence is the control that says, “Actually, I don’t want juice or milk to drink, I want the control to choose what I drink and when I drink it.” That is something else that personalisation is going to offer to those recipients.

Q740 Dr Taylor: Thank you for making that distinction. It is very helpful.

Ms Redmond: Would you mind if I said something about personalisation, because there is a different issue of risk that comes up for families. First of all, families like personalisation where it works well, but one of the high risk areas for them is that in many local authorities where there is a family carer they cut a budget in half automatically before they start talking about personalisation. If you have a 33-year old son with autism and profound and multiple disabilities and he has been at day centre and the family say, “No, that is not the right environment, we would like something much more personalised,” they say, “Ah, right, 50% of the budget, then we are talking.” As a carer, your right to your own life, choice, control, is absolutely out the window. That is a big issue, of people falling out of work and being out of work lifelong, particularly for parents of very severely disabled children.

Q741 Dr Stoate: Ms Corlett, you have talked about brokerage and advocacy at quite length and I have two questions really. Who should provide the brokerages to make sure it is of good quality? Who should pay for it?

Ms Corlett: I think it needs to be commissioned statutorily. I do not see that it needs to be provided necessarily by a local authority. It could be provided by a local Mind group or a local voluntary centre. I do not think that is critical but it does need to be nationally available, so there needs to be coverage. I think it needs to be paid for out of the social care budget. It is part of the overhead of the salary of the individual.

Q742 Dr Stoate: Should there be any restriction on how people should spend their Direct Payments? Or should they be completely restriction free? If you think they should be completely restriction free, then the answer is obviously very simple.

Ms Corlett: It should be legal and it should not cover your really basic needs, by which I mean food, clothes, housing. Other than that . . .

Q743 Mr Congdon: Does anyone have a different view?

Mr Congdon: Can I reassure you that there is a very good document being produced by the Association of Directors of Adult Social Services which lays down the whole legal framework for personalisation. It covers those points, because they have to have a support plan that is agreed. They do have an element of control to make sure things are used very carefully.

Q744 Dr Stoate: I am not worried about that. I am not trying to defend myself against the tabloid newspapers, but I am saying do any of you believe there are any restrictions at all on these things, or should they be literally down to the individual to decide how to spend it, end of story?

Mr Congdon: Legality.

Q745 Dr Stoate: Legality. That is the only restriction. Does anyone have a different view?

Ms Redmond: I would say legal, in principle, but then if you have people who spend their money and then come back for care you might change the rules for those individuals, but I would deal with the individuals rather than punish everybody.

Dr Stoate: Thank you.

Q746 Jim Dowd: Ms Redmond, I just want to look at carers for a moment. Do you think the Green Paper says enough about them? I think I can suggest that the answer might be not, and if not, what does it not say?

Ms Redmond: Spot on there, it is “Not.” I have to say I have not seen the underlying modelling. I have read some of the papers but we have not seen it, but it looks to me like the assumptions are that we will all continue to care and more of us will come and provide the same levels of care that we always have in order to sustain the system that we have. It really misses the opportunity to modernise social care, to work for families as well as the individual who needs care. Our submission talks a lot about how social care is an infrastructure issue that employers need as well as families need. The Green Paper misses that opportunity completely.

Q747 Jim Dowd: On my brief here, I have one of the most misbegotten questions I have ever been asked to put. It says: “How much is known about the extent of informal care and how much it saves the social care system?” That assumes that professional care is formal and anything else is informal. And it does not save the social care system anything at all because the social care system is spending all it can at the moment. I think the question means: What do you know about the proportion between families providing for their own members and being augmented by professional care and how much would that cost were it to be on the same basis as the professional cost?

Ms Redmond: The first thing to say is we know the monetary value of care provided. For somebody who has care needs, we can work out if you had to bring a professional in, then what that would cost. The figure is scary and not something you would ever advocate for spending on public services: £87 billion a year.
Q748 Jim Dowd: Is it reliable?
Ms Redmond: Yes, that is reliable. There is very clear modelling and it has been reviewed. That is the value of care rather than what you would spend on care, if you understand, because families are not going to en masse say, “We refuse to do anything.” That is not what you would want to encourage and you see no signs of families doing less—in fact at the higher levels of care they are doing more than ever before. Families say to us very clearly, “If you get the services right for the disabled person, then I get my life back.” Again, it is that unmet need. That is where you need to focus. For some carers the people they are looking after refuse help from anyone but them and in those situations you want to target services at that person so that they can purchase their own breaks, their own ways of doing breaks, their own ways of getting aids and adaptations into the home. At the moment they are frequently turned away with absolutely nothing because the person they are looking after gets nothing.

Q749 Jim Dowd: In your professional estimation—because this must be a matter of intuition rather than calculation—is it your feeling that carers generally want greater support to be able to provide care to their family member or want more professional care?
Ms Redmond: It changes depending on which group you are talking about. If you are talking about working age, they want more quantity of care coming into the home so that they can continue their lives as well as looking after the people they care for. For older people it is greater support. I would say: it is much more a mutual type of relationship.

Q750 Jim Dowd: The second would be the relationship, say, between spouses.
Ms Redmond: Yes.

Q751 Jim Dowd: Whereas the first was, say, an elderly parent or a child.
Ms Redmond: Or a disabled spouse.

Q752 Jim Dowd: Given the pressures on family life ever present and ever reported and the indication that the nature of the family is changing certainly in terms of generation, is the amount of what this brief describes as “informal care” like to diminish because of those pressures?
Ms Redmond: We see that it is not diminishing but it is taking people to breaking point. There are more people providing high levels of care now than there were in the past. The number of carers in the UK stays pretty static: six million and they churn at just over two million a year. If you think logically about it, if you look at the changed nature of families, if you look at geographical mobility, if you look at women in work, if you look at other government drives right across Europe about extending working lives, all those are pressures that are coming into families as well. If I were more responsible for modernising social care, it would be about responding to those needs as well and understanding that that is part of what we are dealing with here.

Q753 Jim Dowd: Correct me if I am wrong. I think there is a reception in the Jubilee Room at the moment for junior carers. I certainly that that in my diary. I was surprised when I went to my local Lewisham carers at the proportion of minors who are carers for adult, normally a parent. It is a much higher figure than I imagined. How are their problems addressed in the Green Paper?
Ms Redmond: The Green Paper deals with adult care. It does not deal with children as carers, which I think is probably right. If you get adult care right, you take the burden off the children. Children should be children first and should be properly dealt with through the Every Child Matters type of policy, but getting adult care right really makes the difference for children.

Q754 Jim Dowd: It is not to support them but to remove them from the need to provide the service.
Ms Redmond: Yes, and that is government policy in the National Carers Strategy.
Ms Corlett: This is where the fact of the eligibility levels being too high, or is it that they are too low—I can never work that out—but not being able to be eligible is a real issue for child carers. A lot of people with mental health problems might have a child carer and are not eligible for social care. The child stays with the parent. They do not want to leave them at home on their own because they are not quite sure how they are going to be while they are at school, or they are not quite sure that they will eat or some of those things. The eligibility levels really have a massive impact.
Ms Redmond: And mental health and drug and alcohol issues are where you see the majority of children taking on those roles.
Mr Nixon: I would like to add something around flexibility. Where we have this informal care network, which I am sure Ms Redmond would support is invariably desperately fragile and desperately brittle, if we do not have that well supported by a flexible step-up/step-down care service, which when that crisis point comes can step in and take over from the people who are delivering it on an “informal basis”—and I appreciate, Mr Dowd, your comments about the language of that—it all falls down. It has to be responsive. That interface between paid and unpaid care has to be very, very responsive to the delicacy.

Q755 Charlotte Atkins: Ms Redmond, I do not know if you saw the article by Melanie Phillips in the Daily Mail on 18 November.
Ms Redmond: I have not seen it, but I can imagine it.

Q756 Charlotte Atkins: There was something a bit similar echoed in The Times. She said that more state care leads people to shirk their duty to look after frail relatives. I wondered what your take was on that. The Times editorial said something fairly similar. How much responsibility for caring does society have a right to expect from family, friends and neighbours? There seems to be a bit of a
backlash here, that some kind of welfare state is eroding the duty on people to care for their family and friends.

Ms Redmond: Can I tell you that the welfare state is nowhere near the point of capacity to begin to erode the relationships within families. There is not enough in the system. If there were more, do I think people would “shirk” the responsibly for their frail relatives? The evidence that we see is no. I do not see people saying, “I would have looked after my mum, I would have loved her and cared for her, but the local authorities is now coming in with these 15-minute slots, so hands off.” I just do not see it. The evidence is there when you look at the census figures. People are providing more care at higher levels. We do not have that breakdown of care and compassion and love within families. We just do not.

Q757 Charlotte Atkins: Why do you think that someone like Melanie Phillips is getting it so spectacularly wrong?

Ms Redmond: I do not know what her examples are. I do not know where she is coming from really, to be honest. Maybe she knows different families who are saying, “I don’t care about my mum any more,” but I do not see it. It is not evidence based; it is her opinion.

Q758 Charlotte Atkins: What do you think we can do to encourage people more as carers? Clearly caring does get to the point where people are at breaking point. What can be done to encourage people to make that caring responsibility more something they want to do rather than a burden?

Ms Redmond: Certainly in the research we do, most people come at it from wanting to do it. The burden comes in how they have to battle and battle and battle for everything. Certainly our research shows that battling the bureaucracy is what brings them to the point of collapse, not the care of the person they are looking after. That is not the case all the time. In families where they are looking after people with incredibly challenging behaviour, dementia, or learning disabilities with incredibly challenging behaviour, the families are under huge strain. You do not need to encourage them to love their families more; you just need to make sure they get proper breaks and that they get proper assistance, proper help. That is all you need. It is an enabling role that the state should be in. At the moment, if your husband suddenly becomes very disabled after a stroke, and you would think the system would be on your side to get him home, get him into the best condition. That is not what happens. You fight the local PCT about whether or not you are going to get continuing care funding. You have to do means testing, you have to do financial assessments. You have to do all that before anyone will even then allow someone through your door. This might be six weeks/eight weeks after, by which time you are exhausted, your back is hurting, you have lost your job/given up your job. We just need to be on the side of families. I do not see them shirking their responsibilities.

Mr Congdon: I would echo that. The number of parents who bring up their (adult) sons and daughters who have a learning disability has not really changed significantly over the years. About 50% to 60% still live in the family home or are just moved around from long-stay hospitals to residential care to supported living. There is an enormous amount of support from families. The message we have got when we have done the surveys with Breaking Point, in particular of those caring 24 hours a day, seven days a week, up four or five times at night, is, “We need some help. We need a break to recharge our batteries. That would be the real plea, that sort of level of help to enable them to carry on, because they love their son or daughter. They believe, often absolutely rightly, that they give a much better quality of care to their sons and daughters. They know them and they want that support.

Mr Nixon: The comments that Ms Redmond and Mr Congdon have both just made echoes what I would say. It is about this respect for and understanding of a fragile system and making sure that there is appropriate support to help that work as people want it to. They do not want to step away. They do not want to abandon families. They want to see that the person affected by, in my situation, MS gets appropriate care that they can offer in the best way they can. But it is the periphery, the bits around the edge of that, that we need support to make it happen and make it a viable reality over potentially 50 years.

Ms Corlett: A significant proportion of the people with severe and enduring mental health problems who we see have already been abandoned by their families, partly because they do not have the support and they have not been able to cope. It is the opposite, really, of what is being said. For those people, that isolation is exactly why they need care support. The need somebody who is going to pop in and spend a bit of time having a chat and helping to re-motivate the. It is exactly the opposite, really, in many cases.

Chairman: I would like to thank all four of you very much indeed for coming along today and helping us with our inquiry.
Thursday 3 December 2009

Members present
Charlotte Atkins
Stephen Hesford
Dr Doug Naysmith
Mr Lee Scott
Mr Robert Syms
Dr Richard Taylor

In the absence of the Chairman, Charlotte Atkins took the chair

Witnesses: Professor Caroline Glendinning, Professor of Social Policy, University of York, Professor Peter Beresford, Professor of Social Policy, Brunel University, and Mr John Waters, Technical Director, In Control, gave evidence.

Q759 Charlotte Atkins: Good morning everybody. I would very much like to welcome you to the sixth session of our inquiry into social care. I want to apologise, first, for being a bit thin on the ground. You will also have noticed that I am not Kevin Barron, the Chairman of the Committee. Unfortunately, he cannot be with us today—he is involved with a government meeting—so I am filling in as a member of the Committee. Just for the record, I wonder if you could give us your name and the current position which you hold, starting with John first.

Mr Waters: I am John Waters and I am Technical Director for a Charity called In Control.

Professor Glendinning: Caroline Glendinning, Professor in the Social Policy Research Unit at the University of York.

Professor Beresford: Peter Beresford, Professor of Social Policy at Brunel University, but also Chairman of a national independent service user organisation, Shaping our Lives.

Q760 Charlotte Atkins: That is helpful, thank you very much. I will open up with some general questions first, and this is addressed to all you. What do you make of the funding options set out in the Green Paper? Which, if any, do you favour—and why?

Professor Glendinning: From my experience of being involved in the consultation exercises but also looking at the experiences of other countries, I would say that it is a shame that the taxation-based option has been dismissed. In other countries, taxation-based funding for long-term care is common. Scandinavia, Australia and France all use a combination of local and national taxation and user co-payments to fund social care and, indeed, some elements of long-term healthcare as well. I think it is also important to remember that older people are taxpayers as well and that they contribute to the overall tax base. In terms of the other options that are proposed, the partnership model proposes that a proportion of your total needs will be met. My concern about that is that I think it may be very difficult to operationalise with people who have very significant fluctuations in their conditions, or deteriorating conditions, where the amount of money that would be contributed may well change from time to time and, indeed, on a very frequent basis, and I think that conflicts with the kind of commitments and concerns in the Green Paper that people should know what their contributions will be. In the case of fluctuating needs for care, I think that may be very difficult. My concern about the optional and the compulsory insurance schemes, the two options for insurance, are that it risks a two-tier system in which some people can afford contributions but then there are complex arrangements for people who cannot afford to make the premiums that are required. I would just like to point, finally, to the experience of Germany and the assumptions in the Green Paper that we cannot ask for increased contributions from the working age population towards the costs of care. In Germany there is a long-term care insurance scheme. There have been recent increases in contributions to that scheme from the working age population as well as from employers and there has been relatively little controversy over those increases, but I think that is because it is based on an assumption of trust, an implicit assumption that if people make contributions they will receive help when they need it. I think that issue of trust and certainty about future needs being met is absolutely essential in underpinning any requests or expectations for greater contributions.

Professor Beresford: I was commissioned by the Joseph Rowntree Foundation to carry out a consultation on a national basis with a diverse range of adult service users in different situations using different services late in October this year. The key views of that wide, well networked group were, first, that there were problems since the options were not costed, and we still do not know what the costings are. It was felt that the sums identified were unrealistically low, like the first estimates for a new jet aircraft or aircraft carrier. People felt that none of those three options would offer a reliable, sustainable, inclusive equitable basis for social care for all groups. An underpinning concern of the people we consulted was that the Green Paper was framed very much, going back to what Caroline has just said, in terms of seeing service users as a burden and dependent rather than recognising that by providing appropriate support they might be able to be better contributors, so there is a real concern. People were almost unanimous in the view (1) that general taxation should definitely have been included as an option, and (2) in thinking that it was the preferred, more viable option for the future funding of social care.
Mr Waters: I would echo much of what Peter and Caroline have said. I suppose there are two key elements to this. One is the issue that has been touched on in terms of where does any more money come from, but, secondly, how should that money then be administered, and some thought in terms of the fact there does not seem to be great logic to saying that it is unfair to just draw on the working age population for support to meet the social care needs, for the reasons that Caroline has said. But the issue in terms of where the money is administered in terms of the two main areas—either local authorities or the benefits system—if there is movement between those, that needs to be done with some thought in terms of the money that currently is in the benefit system, once it reaches people, is genuinely under their control and is in their hands and they can do with that as they determine. Local authorities, because of the historic pressures and rationing systems, tend to ration through service types. Thus that issue would need to be dealt with very clearly if there was a move away from a national benefits system into a more local system.

Q761 Charlotte Atkins: Could you tell us a bit more about your organisation’s ten-step plan for reforming social care funding and how that relates to the Green Paper options?

Mr Waters: There is a lot of overlap and there is a lot in the Green Paper that, hopefully, draws on some of these ideas. What we have tried to do with the ten-step plan is to identify some of the key issues that face local authorities as they move forward, to inform the debate with some of the progress that has been made and to try and give a practical model to say it is possible to get money into the hands of older and disabled people in a way that defines clearly the conditionality. Why is it that certain people should have a certain level of money and what are the restraints around the use of that money and to focus the restraints, not, as is currently the case, on paying for services, as maybe with direct payment, but in terms of greater clarity in terms of outcome. What is it that is being achieved here? It is a helpful shift to be able to say to people, “Here is a framework of a level of needs. These are your circumstances, the support you can draw from the family, and here are the outcomes that this money is going to help you achieve.” That is quite a powerful thing to be able to do, and our ten-step plan really flows from that idea; that it is helpful to give people a clear entitlement to resources based on both their level of disability but also their social circumstances and, then, what you would need to do to make that a reality, and it begins to explore more fully, and with greater ambition than the Green Paper, some of the integration of funding streams that might need to be taken forward. For example, currently the focus of the rationing of use of the Independent Living Fund is around task and activity—I can spend particular money, but only in certain ways—and it kind of undermines the attempt to get control close to people when really the focus needs to be on the outcome here, and the outcome in that instance is that I get to live in my own home.

Q762 Charlotte Atkins: Caroline, you told us something about the conclusions of your studies into social care funding, but is there a particular system which you think we should copy?

Professor Glendinning: No. I think it is very difficult to make recommendations about a particular country, a particular approach, because other countries have got their own institutions, their own structures, their own cultures and traditions, but I do think it is possible, from looking at a range of other countries, to draw some general conclusions about the principles that seem to underpin care arrangements and funding arrangements in other countries, and I just want to highlight four of them. The first is the principle of universal access based on levels of need regardless of income or assets. Having said that, that universal access dependent on level of need can be linked with and combined with progressive means-tested co-payments; so you have a principle of universality that people, nevertheless, can and do contribute where they are able to. The second principle is equity. Across Europe, across federal systems, where regional governments and provincial governments have very considerable autonomy, nevertheless there are very clear moves to ensure equity across the country to reduce the geographic variations between provinces, between regions. There are also attempts and pressures to create equity for people with different types of disabilities as well, and particularly equity between, say, older people with cognitive impairments, who often get less than people with physical impairments. The third area of equity is around age groups as well. Many other countries have the same arrangements for a disabled child of the age of five up to an older person of the age of 95. That equity principle is important. The third issue is around cash or services: do we give people cash payments or do we give them help in the form of services? Many countries are experimenting with cash payments, and they have different underpinning rationales, but I think one of the conclusions from the experiences of other countries is that giving people cash on its own does not necessarily stimulate the growth of a provider market. It does not mean that providers respond with a wide range of flexible responsive services. The fourth issue, which is linked to that, is the role of family carers. All countries recognise that carers are absolutely crucial to the long-term sustainability of social care systems, and arrangements and support for carers are often built into the wider social care arrangements. Many countries, nevertheless, offer what we might term a “carer blind” assessment, so that the help that you get is entirely dependent on your needs for help and it does not take account of whether or not there is a carer there, a family member, who can provide some of it. The other thing (and this is where it comes back to the cash payment issue) is that reliance on cash payments, care allowances, as the main form of support can very often trap families and trap carers, because there are no services as an alternative to their labour. I think the cash payment issue and the impact on carers is a very big one that needs to be thought about very carefully. Indeed, in some countries, like Italy and
Austria, some families have opted out of providing very heavy amounts of care and are using care allowances to employ “grey” migrant care workers who live in the home of the older person. Cash versus care is an important debate, but my view is that where cash options are available they need to be underpinned by services as well.

Q763 Charlotte Atkins: Scotland has had free personal care since 2002. What is known about how well that is working? Is it affordable? Has it proved to be affordable?

Professor Glendinning: It has been politically very popular, and it remains politically very popular. It is not clear that demand for services or demand for personal care has increased; there have been wider policy changes and demographic changes that have affected costs anyway. The research that has been done, particularly from the University of Stirling, has shown very marked variations between local authorities in the level of additional costs that they have had to bear but, also, there are some big weaknesses and shortcomings in the data that is available both at local authority and at national level that would enable the future costs of free personal care to be properly estimated. Indeed, the Scottish Executive has been criticised for introducing the policy without a clear understanding of the long-term costs. There is still a shortfall in the data that is available to help understand the current and longer-term costs.

Q764 Charlotte Atkins: You were suggesting that some local authorities had greater costs than others. What was that based on: the nature of their populations?

Professor Glendinning: It is partly based on demography, partly based on the number of people who were previously funding their own care who came into scope for free personal care. Of course, free personal care is offered to people in residential care as well as in their own homes. To the extent that local authorities are able to shift the balance of care into the community and away from residential care, there is the potential to contain some of the costs of free personal care.

Q765 Mr Scott: Perhaps I will start with John. What are your views on the policy set out in the Queen’s Speech about providing free personal care for those with the greatest need? Could you see any unintended consequences of this policy?

Professor Glendinning: Shall I go first? You go first.

Q766 Mr Scott: Do not fight over it!

Professor Beresford: No, no, I think we are of similar minds on many issues here. The real concern that I have personally is if we have ruled out as an option considering general taxation in a Green Paper to which there have been 24,500 responses, a significant number of which have supported the idea of general taxation at least to be included, then it feels like it is policy being made on the hoof to introduce a new idea which contradicts that. We carried out our national consultation after the announcements had been made, both about the Government’s proposals and the Opposition’s proposals, and I think what people said is really the way I would feel about this. For example, what is “critical”? Who decides and how, and what if your needs fluctuate? I think it is difficult to answer. One of the things that concerns me is when you make an intervention in one part of the system, you can have unintended consequences in other parts of the system. I think if you say we are going to provide free domiciliary care, my question would be: what happens to the rest of the system? I think what people are saying is: does that mean that to offset costs fewer and fewer people will be seen as having appropriate qualifying needs, and would that mean that there will be perverse incentives, for example, for people either not to receive support that could prevent things getting worse or, alternatively, for people to be seen only as candidates for residential care? I think, unfortunately, if you do touch one piece you need to look at the whole, and that is the worry about this proposal.

Professor Glendinning: I think there are some interesting lessons from Scotland here, because it is very similar to the proposal in Scotland, apart from the fact that in Scotland free personal care is also funded for people in residential care. Scotland has got some interesting new boundary disputes about what is personal care and what is domestic help. 20 years ago we were arguing: is it a health bath or a social care bath? In Scotland there are now debates, for example, around eating and feeding, so you get into situations where helping people to eat is personal care, food preparation in some local authorities is regarded as domestic help and, therefore, is a charged-for service, so you are creating new boundaries in the system. I think, also, that means the potential for some really complex financial assessments and to the extent that non-personal care will still be charged for we will have local authorities trying to assess what proportion of a care package is non-personal care and, therefore, subject to means-tested user charges. I think that kind of division is incompatible with other policy objectives, particularly the policies of personalisation which are based on assumptions about flexibility and user control. You are looking at a package of support that somebody gets and beginning to put up boundaries round, “You can use this for this and that for that”, and I think that is incompatible with the broader policy of personalisation.

Q767 Dr Taylor: This is really addressed specifically to Peter. You have picked out some splendid words that service users want to be cared for by workers with vital human qualities, and you have listed them: warmth, empathy, honesty, respect and competence, which I think is a brilliant summary. You go on to say that too often they are not treated by these sorts of people. Why is that? What can be done about it?

Professor Beresford: This article in The Guardian was based on a report commissioned by the then Minister for Care, where we spoke to 110 or 112 service users, a very wide range, and over a quarter of them came from black and minority ethnic
Professor Beresford: I think there are micro issues and what you might call macro issues in relation to commissioning. You can see, as we have seen in the big project I have just referred to, the standards we expect where locally people make supreme efforts to make the very best of the resources that are available but, if there is only so much money allowable to pay, whether it is domiciliary care or residential care, and that does not match what it actually costs to provide good care and support, if there are cultural problems in terms of the kinds of people you are recruiting— and domiciliary and residential care is not an area which is constructed and envisaged in career terms as a positive role, although many people, nonetheless, carry it out in that way—then we have problems. There are essentially built-in problems at a macro level is what I would argue.

Q769 Dr Taylor: What can the regulator do? How can the Care Quality Commission going into a home pick up the quality of the workforce, whether they do have the empathy and the warmth that you describe?

Professor Beresford: I think there is a problem in seeing regulation as an appropriate means of dealing with a problem whose origins may lie elsewhere, may lie in problems of supervision, training and particularly of funding and resources, and, of course, regulation can sometimes be a blunt and crude instrument. I think it is very difficult to expect a regulator, especially a regulator like the new Care Quality Commission, which in a sense is required to have a less hands-on role than was previously the case, to compensate for other more substantial difficulties. If, for example, I say to you, checking out a residential service where one knows that the report from the predecessor of the Care Quality Commission was very positive but that when you speak to a resident there they do not even realise that they are permitted to go into the garden, you realise, of course, there is a big gap, many a slipp 'twixt cup and lip, between what it is possible to do by a regulatory system (and that too much is expected as such) and what needs to be achieved in terms of other change. One of the things that service users feel very strongly is that they rely on regulation and registration as a cure-all and it is not going to work. They recognise that there are problems of a more face-to-face fundamental issue than a regulator should be expected to resolve.

Q770 Dr Taylor: So low pay, poor training and time for doing tasks are really the vital things?

Professor Beresford: I think that they are, and I think also that there is a low value placed on such work in our society. I think it is interesting that very recently we have been able to read in The Guardian—and we know this is the case—the way that immigrants are being exploited to undertake such work. It is because it is not a job that, unfortunately, people can see as offering an adequate career for the future, it is an entry job, and I think for that to be true is an appalling indictment of our society; the value it
places on the human and personal needs of people who are having difficult times or who are at difficult ages.

**Q771 Dr Taylor:** Certainly in my area at home, care workers in residential homes are Filipinos, and they do a splendid job.

**Professor Beresford:** Absolutely.

**Dr Taylor:** Thank you.

**Q772 Stephen Hesford:** Mr Waters, your organisation In Control claims to have conceived and developed the concepts of personal budgets and self-directed support. Can you tell us how you came up with these ideas and what shape they take?

**Mr Waters:** I suppose they have evolved over a number of years and they came from a recognition of some of the problems that we have been talking about this morning. The intention really has been to say how is it possible to fairly share resources that are available to local people and to place the decisions about how resources should be spent as close to people as possible, whether that is the person themselves or, if they do not have capacity, their family member or, in some circumstances potentially, a social worker or somebody advocating on the person’s behalf. It was the intention to say how do we get control close to people when previous systems had struggled to do that. We have heard Peter talk about some of the difficulties with the way services and the workforce operate at the minute. We worked initially with six local authorities for a couple of years and we said here are some core ideas about what a personal budget might be and some ideas building on the work that then happened around person-centred planning to say, “Is it possible to get control close to people? What are the tensions in there? How do you solve some of the debates around what is good use of public money?” and we have done that by working together with families, people themselves and particularly with local authorities and challenging them really to change their systems within the parameters to which they operate. That work has moved forward over six or seven years now and we have produced a couple of significant reports that have said: this is the emerging model, this is the effect that we think this approach can have in terms of getting control close to people. The key issue, I think, is this idea of partnership—getting control of resources close to people but sharing out resources fairly to people using a transparent framework that allows people to identify their own level of need and what for them is a fair allocation of resources—and to tie into that a clearer idea of what is the outcome here. For example, one of the outcomes might be to maintain family relationships. Quite clearly, the Green Paper says one of the things that services should do is support maintenance of family relationships. We have taken a step back from that idea of services and said overall the system should be doing this and that the financial resources should be under the control of the person and, so long as they are used in a way that can be agreed to achieve those outcomes, then it should be the person who decides and not the commissioner or the local authority who decides.

**Q773 Stephen Hesford:** There is a term that we have got from you called “total transformation”. Can you tell us a bit more about that?

**Mr Waters:** That is just the name that we gave to a piece of work that we took forward. This started off before the Green Paper had set out any of these ideas, before *Putting People First* had said that personal budgets were a helpful way to organise social care, but we had a lot of interest from local people and from local authorities, who were saying, “We recognise the value in this approach and we recognise that we cannot just operate in small-scale pilots. We cannot make it available to somebody with a learning disability but not to an older person, or somebody in this area and not in this area.” So we responded to that and we said, “We will work with you and figure how do you begin to change your whole system?” and we called that total transformation. We worked with about 20 local authorities to support them to begin to think through the bigger systemic changes they need to take through.

**Q774 Stephen Hesford:** One former government minister, in simple terms, described your organisation as being fantastic.

**Mr Waters:** That is very kind.

**Q775 Stephen Hesford:** What exactly is your relationship with government and to whom are you accountable?

**Mr Waters:** We are a charity, so we are accountable to a board of trustees. Our main funding comes from a subscription from local authorities and we provide a support service to local authorities, figuring out how to meet the demands that are being placed upon them. So we are accountable to a board of trustees but, also, we would not exist if local authorities did not think it was worth supporting our work.

**Q776 Mr Scott:** Direct payments have been made since 1996, but the take-up has been very low. Why do you think that is?

**Professor Beresford:** I think it would be helpful for us to contextualise the terms “individual budget” and “personal budget” with “direct payments”. Direct payments were an idea that came from the disabled people’s movement, and what they were crucially about was making it possible for people to have more control over the support that they had and more control over their life, and, sadly, this is still a problem for many service users, many people have not experienced. I can remember one of the first things that my organisation did was a project concerned with measuring outcomes and trying to develop user-defined outcomes. Not just what professionals thought outcomes should be, but service users. When we put that together in a video, we discovered that the only people who could talk about outcomes and for them to have any meaning for them were people who were accessing direct
payments. Only they were seeing appreciable change in their lives from the support that they were receiving. There is so much evidence to show how well direct payment can work, but we know that there have been obstacles, in the sense that their take-up has always been different in different parts of the country, different local authorities have been more or less enthusiastic, that many social workers have not had the support to understand them or have been able to implement them well, and, of course, what was the case with direct payments was that few promises were made that this would be a cheaper way of offering support. It was made very clear that this should be, and could be, a better way of offering support. One of the things that we have seen with the more recent discussions, which is why they have gained so much political support, has been claims made that they can be much cheaper, and I think that those claims need to be subjected to far more careful scrutiny. What was said about direct payments was that they could make it possible for people to live a fuller more contributory life, and that was in accordance with values of a philosophy that the disabled people’s movement developed called “independent living”, not meaning standing on your own two feet, but having the support to be a contributor—to be able to go to work if that is what you wanted, to get an education, to sustain relationships, to be a parent, rather than have someone coming in and getting you up at the time of their choice, putting you to bed at six o’clock, and so on and so forth. I think there were problems in the way the process was implemented, and I think disabled people have often felt that local authorities were not the ideal implementer, and I think many of the gains that we have seen come with individual budgets have been because there has been the opportunity to get back to the true spirit of direct payments, which was: you should know what resources are available and truly have control over them and, of course, have the support to run the system. That is what was seen as the most important: there should be an infrastructure of support—advice, guidance, management, knowledge—from local service user organisations, something which the Prime Minister’s Strategy Unit said we need to go ahead and have a network of nationally in this country, but that has not always, unfortunately, been in place. I think we are seeing an extension of continuity to some extent a rebranding and, I think because there is now more political will there is much more chance of this working.

Q777 Mr Scott: Caroline and John, would you like to say anything?

Mr Waters: My thoughts are that I agree entirely with Peter’s comments. I think there is a significant issue in terms of direct payments have operated almost as a bolt-on to the main way that local authorities conduct their systems. A social worker supporting one of their clients to take up direct payments would have to be following a completely different set of processes and procedures. They would have to find the time in their work to sit down and develop a good person-centred plan with somebody, and that takes time; it takes energy. It is often what folk want to do and is the right thing to do but they are faced with the choice of saying there is a pre-commissioned, ready-made solution here where I can pick up the phone and I can move on to my next piece of work. So it is partly because it has been a bolt-on.

Professor Beresford: Could I add to that because I think that is a helpful comment and I would not disagree. I do not think that is a statement actually about good social work. If one looks, for example, at specialist palliative care social work—and there are cases of individual budgets and direct payments in specialist palliative care, where there is a much more informal, thought through partnership approach to assessment—you can see exactly what John has described taking place. I think what the problem has been is that the care management introduced in the 1990s has not sat comfortably with these ideas of self-directed support.

Mr Waters: The other difficulty, in terms of uptake, was clarity around the level of resources that any one person should have available to them, and that often was decided at the end of an assessment process once a service had been costed and, in order to control and manage and ration local resources, local authorities would place quite clear restrictions on the things that direct payments could and could not be spent on, starting perhaps down to a list of preferred providers, but then, even more tightly, down to certain tasks and activities, because there was a lacking of any sense of how much of a fair allocation should be made available.

Professor Beresford: Could I pick up on that one because again that is a very valid point. One of the troubles we are seeing now is exactly the same happening with local authorities interpreting personal individual budgets in just the same way. I could point to an inner London borough which has made it clear to people that if they want to spend some of their personal budget on cleaning, it will deduct that amount from their personal budget, and it has only been in the case of some people who have taken that to all forms of complaint and appeal that they have managed to reverse that decision. There has been a cultural problem, which continues, of local authorities’ understanding of an open menu, I think, here.

Professor Glendinning: I would add one point, and it is drawing on evidence from the Netherlands, where there is a similar personal budget scheme in operation. Again, take-up tends to be higher amongst younger disabled people but, nevertheless, older people do use personal budgets. The crucial difference is that the Netherlands allows personal budget holders to employ close family members, including spouses, and I would not want to say that employing close relatives is always easy—it can bring its own problems—but for older people being able to pay a close family member to provide care is sometimes more acceptable than employing a personal assistant in a much more formal employer relationship.

Mr Scott: I think employing family members is something that Members of Parliament can relate to!
Q778 Stephen Hesford: Professor Glendinning, can you summarise briefly for us the findings of the individual budget pilot?

Professor Glendinning: Yes. To some extent this supports the points that have already been made about the difficulties and the challenges of transforming a system. I think all the pilot sites extended the scope of their pilots during the two-year pilot project and, indeed, some of them had decided to introduce individual budgets across the whole of adult social care during the course of the pilot. They found it was very difficult to run the two systems in parallel so the pilot sites were beginning to move towards this kind of total transformation. The outcomes for older people were not as positive as for other groups of people. The outcomes for people with mental health problems were very positive and there was actually some suggestion there that people with mental health problems were opting for personal budgets, or individual budgets, where they had previously refused to use or not been willing to use conventional day care services, day centre services, and so on. There was some evidence of increased demand there and people with mental health problems tended to use their personal budgets, individual budgets, for leisure activities—adult education classes and those kinds of things. Part of the reason, I think, for the less than positive outcomes around older people was that—

Q779 Stephen Hesford: I think we have got a question on that, so if we can just park (a rather inelegant phrase) older people for a second, we will come back to that.

Professor Glendinning: Okay. I think one of the important points and one of the important findings of the evaluation that I do want to highlight was the failure to really tackle the issue of integrating funding streams, and this is where individual budgets differ from the personal budgets that are now being implemented by local authorities. Individual budgets were intended to bring together the resources.

Q780 Stephen Hesford: If there was a quick, for our benefit, definitional relationship between individual budgets and personal budgets, what is it?

Professor Glendinning: Individual budgets were intended to bring together multiple funding streams—resources from Social Care, Access to Work, Disabled Facilities Grants, Supporting People, Independent Living Fund—so resources from DWP funding streams and DCLG funding streams. The personal budgets that are now being implemented under Putting People First are social care resources only, and I do want to emphasise that this was probably the most disappointing element of the pilots. The proposal that individual budgets should include these different funding streams came from the Prime Minister’s Strategy Unit report in 2005, and it was an attempt to reduce the complex set of multiple assessments, multiple eligibility criteria that disabled people and older people have to go through. The pilot sites were very excited at the prospect of being able to try and bring together funding streams, but they found it very, very difficult, largely because of restrictions at central government level on what the different funding streams could be used for and accountability for how they were used. That was one of the really difficult areas. Of course, the other really difficult area was the fact that although all these funding streams were included in individual budgets NHS resources were not. So there were major problems at the NHS/social care boundaries, particularly around continuing healthcare and mental health services, where people very often used both health and social care resources. So, individual budgets, multiple funding streams, personal budgets and social care resources only.

Q781 Stephen Hesford: I think you have probably answered this, but was there anything that came out of the pilots which still seems to be hanging in the air?

Professor Glendinning: I think the funding stream issue is one, and, of course, since the IBSEN evaluation has been completed, the Department of Health is now piloting personal health budgets. We are still very unclear about how they will interface with social care personal budgets and the Department for Work and Pensions is discussing the piloting of right-to-control projects, which will include some of those IB funding streams—it will include Access to Work and the Independent Living Fund. I think the whole issue of cross-departmental working to try and simplify all the different resource streams and the assessment processes that go with them is a major issue that remains to be addressed and it links to the Improving Life Chances strategy. I think there are some other issues we have touched on already about what it is legitimate to spend public resources on. What are the boundaries on what people can use their personal budgets for? I think we need a much bigger debate around that, and I think it is something that government needs to lead on, because the uncertainty about what people could spend their money on really restricts creativity both in terms of frontline staff and personal budget holders and I think we also need a bigger debate on how we actually allocate resources to people. The resource allocation process that In Control pioneered and was very, very influential with many of the pilot sites, in a sense, by-passed a bigger question about what criteria we should use, what levels of resources we should allocate to which groups of people, and, of course, it revealed big inequities. It revealed very clearly that older people get far lower levels of resources than other groups of service users. I think those are some big debates that still remain.

Professor Beresford: Can I add something to that. I think it is very helpful to hear set out in a very clear way things that are not always set out very clearly at all, but we need to remind ourselves that the Government made a commitment back many years ago to transforming social care services, and one of the findings from the preliminary work we have completed in the national project supported by the Joseph Rowntree Foundation is just how many
things need to change and be got right systemically at local and central level if you are being serious about actually transforming—and I think that comes across very strongly also from what Caroline has said—and, therefore, it is a worry to service users who have been long-term service users, who have experienced wave after wave of policy change which has not been reflected in positive change in their day-to-day experience, but the same might happen now, because we are using very large words like “transformation” but not necessarily recognising that if we are talking transformation it actually does mean that, and it is an enormous thing to be aiming for. On the ground, service users and, of course, practitioners are concerned.

Q782 Stephen Hesford: Can I come back to you, Professor Glendinning. The Government have moved towards personal budgets. Am I right in thinking that what you are saying is they were driven to that because of the complexity of operating individual budgets, or is there some other explanation?

Professor Glendinning: I do not know. I do not know the reason for the decision. The decision to roll out personal budgets across English adult social care was, of course, made before the findings of the ISEN evaluation were available. I do not know. My own personal view is that it was a political decision. I am not aware of any clear evidence underpinning that decision.

Q783 Stephen Hesford: Is it a done deal, or is there a way back, or should we move on?

Professor Glendinning: I think certainly the experience of the individual budget pilots (and I am sure John would reinforce this) the processes of developing different ways of allocating resources, different ways of agreeing with people what they might use those resources for and accounting for them, the issues about risk and safeguarding that are related to it, and there are some very big issues as well around service commissioning that we have not touched on—I think the changes that are involved in all of those things would make it very difficult to go back because I think it is a total transformation. It is a transformation in culture and in operating systems throughout adult social care.

Mr Waters: Can I take a quick opportunity to add to what Caroline has said in terms of clarifying the issues in terms of a resource allocation system. Quite clearly, it was the work around the resource allocation system. It caused a lot of folk to realise some of the differentials across different social care groups; it was not the innate cause of those. The system had been operating and older people had got, on average, significantly less than other groups, but it was not the shift towards personalisation or personal budgets that caused that, that was already part of the system, and I think our work has demonstrated some very practical and simple solutions to some of these key problems and a much greater focus on outcomes around a fair deal. Added into that a capacity to begin to begin to define how much support is it reasonable to draw from those people around you, from your family; how do you define that? There were some very practical problems that needed to be solved to move on. In terms of the funding integration, a lot of the difficulties and issues there were very predictable and were predicted. A colleague of mine, Simon Duffy, and I prepared a paper predicting some of these difficulties and there were attempts to solve or to ask local people to solve problems that should have been solved centrally. Where there needed to be an alignment around the means-testing arrangements or the charging arrangements, the restrictions, these were set in statute or in trust deeds that quite clearly needed to be removed and flexibility given to local authorities and to local people. So these things were predictable. They are not massively complicated. You can quite clearly say, if you begin to set out a way of measuring need, if you begin to set out what a fair deal looks like, if you begin to set out some clear outcomes for people, they can then bring on and draw from their own resources and their own creativity. If you help people plan and focus, not just on the money, we begin to see some better outcomes, and a lot of the feedback that I have when I talk to folk nationally is the emphasis often is in the wrong place around personal budgets and ignoring that actually it takes a lot of effort and a lot of time to sit down with somebody and figure out a decent plan that will work for them and their life. The focus often goes on to how we manage the budget, and that is only part of a bigger system.

Professor Beresford: I would like to get back to some basics because I think it is very helpful. I think there has been a problem with this debate more generally in that there has been a tendency to focus on means, not ends. There has been an enormous focus on individual budgets and personal budgets, and we know that they offer good things and they also have serious and continuing problems. I think what we need to remember is that if there is not enough money in the system, as there does not seem to be (and, do not forget, what you get is ultimately bound by your role and your place in the eligibility criteria system) it means that what it is, apart from being top-sliced for its own administration, is points for prizes, as people call it, which ultimately is a rationing system, and what distinguished the newness of the idea of direct payments was that there was an independent criterion, which was how would this make it possible to live your life independently, and I do not think that is strongly there. I think the issue was never that moving to cash should simply be a financial transaction. We know that the group of people who do that routinely—self-funders—is the group most vulnerable, often unnecessarily, to institutionalisation, to moving into residential services. It was intended as a shift in power; and I think a lot needs to be in place, not least some of those things which have been talked about by Caroline: the idea of a system of infrastructural support, advice, guidance, of local organisations of service users, neither of which is truly in place, both of which have financial implications.
Professor Beresford: One of my other roles is to be centre”—that kind of choice—but that involves Next week I would like to go to the garden say, “Okay, I would like to go shopping this week. a week that is unallocated and the older person can allows some flexibility—for example half an hour and control, because the contract with the provider want the care manager to manage their personal commissions, for example, home care services with authorities are now beginning to do is to back to the local authority to say, “Please purchase V commission the purchase of services on my behalf.” You can give it to a service provider and, in a sense, call off packages of care as and when you need them. You could ask a third party, a carer or a trust to manage it for you. Those deployment options are very important because what all the research on direct payments has shown is that older people are not necessarily comfortable with the cash and being an employer, and I think that is an important issue. Certainly looking at the individual budget pilots and the evaluation and the evidence from that, older people were often very frail by the time they became eligible for social care, perhaps had fluctuating and deteriorating health problems, even if they were already receiving services, as Peter said. You have picked up the issue of the relationship with the people who provide your care, and, I think, certainly with the individual budget pilots, some older people may have experienced the pilot as a threat to that stability and the trusted relationship—it did not have to be, but that is how they perceived it—and, of course, they received lower level of resources, the bulk of their personal individual budgets were used for personal care because that was an absolute priority, and they had less scope within the resources they were given for those more creative things, using the money for social activities and improving other areas of their lives. This picks up the question about service commissioning because, for older people in particular, they may well want to hand the budget back to the local authority to say, “Please purchase services on my behalf”, and what some local authorities are now beginning to do is to commission, for example, home care services with a greater degree of flexibility, and I think it is absolutely vitally important that older people who want the care manager to manage their personal budget, nevertheless, have opportunities for choice and control, because the contract with the provider allows some flexibility—for example half an hour a week that is unallocated and the older person can say, “Okay, I would like to go shopping this week. Next week I would like to go to the garden centre”—that kind of choice—but that involves changes in commissioning practices as well.

Professor Beresford: One of my other roles is to be a trustee of the newly established National Skills Academy for Social Care, which has a role in trying to advance the quality of practice and provision in social care. One of the strands of work that we have been undertaking since we were set up has been around personal employers and personal assistants, and we commissioned some research, and what is interesting is the very low level of knowledge and understanding that there is across all user groups about having a personal assistant and also personal assistants not knowing a great deal about it themselves, often being quite isolated. I think there is a broader issue here. If you have had a life as a service user, or if you enter as an older person needing social care, where was the guidance, the tutelage, to be a very active person in the relationship? Historically, you have been expected to do what you were told, take the service that was offered, and, suddenly, we are saying the opposite to people. People need support to get to the starting point to be able to make choices and decide what they want. I think that helps explain what Caroline is saying. Older people are not one homogeneous group, they are incredibly diverse. There will be some older people, as some people of working age, who really would not want to do it—either take on a personal assistant or not have the money—but there might be many more that would. In Hampshire, where they carried out a national commission on personalisation, but they have got one pilot site where they have been taking forward the insights they gained from their activities around personalisation, they have told me that they have actually had a higher number of older people opting to go on personal budgets than of other age groups, but I think they put in place strong systems of support, and that is the bottom line of everything that I have got to say. If you want all this to work, you have got to help people be able to do it, and I say that speaking as someone who used mental health services for 12 years and I look back and I think: when this started to happen to me all the obvious things that you do to do the right thing to cope go out the window. When you have difficult times, when there is a crisis, if your condition is bad or gets worse, you do not know all the right things to do; you need lots of help to do it.

Professor Glendinning: I will come back to that, but what I want to do, first of all, is to spell out that you can use personal budgets in different ways, and I think this is important to my part of the answer. In a personal budget you do not necessarily have to take the cash option. A personal budget: you can hand it back to your care manager and say, “Please commission the purchase of services on my behalf.” You can give it to a service provider and, in a sense, call off packages of care as and when you need them. You could ask a third party, a carer or a trust to manage it for you. Those deployment options are very important because what all the research on direct payments has shown is that older people are not necessarily comfortable with the cash and being an employer, and I think that is an important issue. Certainly looking at the individual budget pilots and the evaluation and the evidence from that, older people were often very frail by the time they became eligible for social care, perhaps had fluctuating and deteriorating health problems, even if they were already receiving services, as Peter said. You have picked up the issue of the relationship with the people who provide your care, and, I think, certainly with the individual budget pilots, some older people may have experienced the pilot as a threat to that stability and the trusted relationship—it did not have to be, but that is how they perceived it—and, of course, they received lower level of resources, the bulk of their personal individual budgets were used for personal care because that was an absolute priority, and they had less scope within the resources they were given for those more creative things, using the money for social activities and improving other areas of their lives. This picks up the question about service commissioning because, for older people in particular, they may well want to hand the budget back to the local authority to say, “Please purchase services on my behalf”, and what some local authorities are now beginning to do is to commission, for example, home care services with a greater degree of flexibility, and I think it is absolutely vitally important that older people who want the care manager to manage their personal budget, nevertheless, have opportunities for choice and control, because the contract with the provider allows some flexibility—for example half an hour a week that is unallocated and the older person can say, “Okay, I would like to go shopping this week. Next week I would like to go to the garden centre”—that kind of choice—but that involves changes in commissioning practices as well.

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Q784 Dr Taylor: This is your cue, Caroline, to come back on the older people and why they do feel so much less comfortable. Is it just because they are not confident, they do not get the advice and the guidance that has been said, and what can be done about it?

Professor Glendinning: I will come back to that, but what I want to do, first of all, is to spell out that you can use personal budgets in different ways, and I think this is important to my part of the answer. In a personal budget you do not necessarily have to take the cash option. A personal budget: you can hand it back to your care manager and say, “Please commission the purchase of services on my behalf.” You can give it to a service provider and, in a sense, call off packages of care as and when you need them. You could ask a third party, a carer or a trust to manage it for you. Those deployment options are very important because what all the research on direct payments has shown is that older people are not necessarily comfortable with the cash and being an employer, and I think that is an important issue. Certainly looking at the individual budget pilots and the evaluation and the evidence from that, older people were often very frail by the time they became eligible for social care, perhaps had fluctuating and deteriorating health problems, even if they were already receiving services, as Peter said. You have picked up the issue of the relationship with the people who provide your care, and, I think, certainly with the individual budget pilots, some older people may have experienced the pilot as a threat to that stability and the trusted relationship—it did not have to be, but that is how they perceived it—and, of course, they received lower level of resources, the bulk of their personal individual budgets were used for personal care because that was an absolute priority, and they had less scope within the resources they were given for those more creative things, using the money for social activities and improving other areas of their lives. This picks up the question about service commissioning because, for older people in particular, they may well want to hand the budget back to the local authority to say, “Please purchase services on my behalf”, and what some local authorities are now beginning to do is to commission, for example, home care services with a greater degree of flexibility, and I think it is absolutely vitally important that older people who want the care manager to manage their personal budget, nevertheless, have opportunities for choice and control, because the contract with the provider allows some flexibility—for example half an hour a week that is unallocated and the older person can say, “Okay, I would like to go shopping this week. Next week I would like to go to the garden centre”—that kind of choice—but that involves changes in commissioning practices as well.

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Q785 Dr Taylor: One of your big criticisms is lack of training and instruction and how to access and decide upon the services?

Professor Beresford: It is not a criticism; it is a statement of one of the essentials we need to have in place to make this transformation really work. People need to have help—whether they are someone with learning difficulties or an older person—and we cannot assume that the family can do it. Lots of people are old and do not have that family, some people are isolated, some people do not want to turn to their family. They need to have some option of exterior support. One of the recommendations of the Hampshire Commission was that there did need to be this infrastructure of information, advice, advocacy and support for it to work well.

Q786 Dr Taylor: Caroline, turning to the Netherlands, I think it was the Netherlands, you say, where people can employ their own family.
With personal budgets, if you take a cash option in this country, why could you not employ your family?

**Professor Glendinning:** At the moment you are not usually able to employ a close co-resident relative. That is the current regulation. Obviously, exceptions may be made for people, for example, in very rural areas where there is nobody else, but it particularly prevents older people paying a spouse. I think we need to bear in mind that as the population as a whole ages, carers age as well, and there are increasing numbers of elderly spouse carers. So that is probably the main restriction. Having said that, it is not the answer for everybody. Certainly I have come across anecdotes where real problems have arisen through the employment of family members. So it is not an answer for everybody, but it does seem to be popular with older people in the Netherlands. Having said that, one other big difference is that for carers who are employed above a certain number of hours per week in the Netherlands, that employment has to be properly regulated and it has to comply with minimum labour regulations about contracts, terms of employment, holiday pay, sick pay—all of those kinds of contractual things. I have not come across anybody who has objected to it. Older people do say, “It is strange having this contract with my wife”, but I have not come across any evidence that it is a problem.

Q787 Dr Taylor: I think that is great. Should it be one of our recommendations that there is flexibility for the use of personal budgets? If it is right for a certain person to employ their spouse, they should be able to do that?

**Professor Glendinning:** I think that could be a useful recommendation, so it is about being more flexible in who you can employ and how you can use the personal budget, but I do want to emphasise the other options as well—giving your budget over to the care manager who can purchase a flexible range of services on your behalf, giving the money to a service provider and calling off packages as and when you need them—and local authorities are beginning to work with their local service providers to support the providers in delivering these more flexible options, and I think that is essential as well.

Q788 Mr Symes: Should people have the right to choose not to choose and just keep the services they have got if they are happy with them?

**Professor Glendinning:** I will say very quickly that at the Social Policy Research Unit we are doing a major study into how people experience and respond to choice over time. It is very clear that different people want different choices about different things. Choice may be very important in relation to housing options but much less important in relation to health treatment. I think it is a very individual choice.

**Professor Beresford:** I have noticed that government does talk a lot about choice, users talk a lot about control, and they are different, and there are tensions. For example, in relation to day services (and I can speak particularly in relation to mental health service users) mental health service users are seriously concerned about the disinvestment/closure of day services. There have been day services, day centres for mental health service users and people with learning difficulties that have not been good, which have just been, as it were, waiting rooms, but what they can be (and some are) is places where people can feel safe, have relationships, get support and have a springboard to other things. If you talk to mental health service users—I have heard this so many times—people say, “It is not often safe outside. If I behave in a way or am seen to be different or weird, people may not be nice to me. I like to be somewhere where it is not like that. I would love to go to a café, but it is £2 for a cappuccino. I would like to go somewhere where I can feel reassured.” The worry is, of course—and I think Caroline referred to this—how do you sustain two different systems at the same time, but the bottom line is, if we are talking about personalisation, we must be offering the kind of choice that is implied in your comment.

Q789 Mr Symes: Should day services for a centre be ringfenced?

**Professor Beresford:** I do not see how you can ringfence one service and not another. I think, assuming, in simplistic terms, that the move now has to be to pushing people into employment and disinvesting from services that seek to enable people to have a chance for that and for other things is crude and does not recognise the complexity of mental health issues, the capacity for people to be able to move on but the needs that some have at any time to be somewhere safe.

**Mr Waters:** It is important to recognise that choice operates at both ends and that just by identifying a particular service model to say, well, if some folk choose to take their personal budget and spend it on other things that will destabilise what is there and, effectively, not be a choice for some of the existing service users—that is very much an issue that needs to be borne in mind by commissioners. Equally, though, the opposite is true. I have managed many, many services over many years and known that the large numbers of people who go there, given a genuine choice, would not be there and have, with increasing choice, seen people vote with their feet. You need to say that this is a double-edged element and it is not a simple thing. Clearly, there are some things that you would say should be ring-fenced. You do want an infrastructure—and those would be the things that Peter and Caroline have talked about—and you need to make sure that there are good advice, support, planning and advocacy systems available to people.

**Professor Beresford:** User-controlled services, user-controlled organisations.

**Mr Waters:** There is an infrastructure that works for a new system that enables people to make informed choices and to take control, and those would be the sorts of areas that you would say that, if you want to protect something—the protection of vulnerable adults—you would need to have a system in place to see that there is an independent, most probably, local authority led body that takes that forward. You would not want to let that disappear. So there are
clearly things in the system where you would say a helpful infrastructure is helpful. When you start getting into direct service provision, you need to bear in mind that choice is not an all or nothing for the folk who end up in systems. If the local authority has pre-purchased a bed in a home, they are going to use that and somebody is going to end up in there, so if that is committed, then that person’s choices are restricted.

Q790 Mr Sym: Do you think it would be practical for individual service users to collectively commission services, whether it is a day centre or a dance class? Do you think that would be practical or do you think that would be local authority led?

Mr Waters: There are examples in the traditional system for many years where local families of people with learning disabilities potentially will have gathered together and set up a service. There is nothing to say that that cannot happen. There are some pilots under way exploring this issue more formally, in terms of personal budgets, with a housing association piloting some work in this area, but it is fairly early in terms of the idea of personal budgets and collaboration.

Professor Beresford: Coming from the other end, for at least 20 years there have been efforts by service user organisations to establish collective services run by service users, and a major piece of research by the National Centre for Independent Living and the Centre for Disability Studies at Leeds University reported an evaluation of that and those services were particularly valued. What worries me, though, is that we have a Government, and I am sure an Opposition, which is committed to a plurality of services is, I think, not always realistic, nor should it be assumed that carers will do that for them.

Professor Glendinning: I just want to add a reminder that older people are the biggest group of social care service users and reiterate my earlier point that people, by the time they become eligible for social care, are often fairly frail, may well have health problems, and the notion of organising your own services is, I think, not always realistic, nor should it be assumed that carers will do that for them.

Q791 Mr Scott: It seems widely acknowledged that brokerage, advocacy and advice are an essential part of putting people’s own care packages together. Who do you think should provide it and how should it be paid for? Could I perhaps start with John?

Mr Waters: In terms of the total transformation that we have been talking about, there is clearly an issue. Large sums of money go on the transaction of the system already, and one of the dangers is that if you suddenly invent a new profession of brokerage, you end up saying, “Well, how do we fund that?” and you take money out of the hands of disabled and older people. Clearly, in terms of funding, one constraint will be you do not want to add to the transaction costs here. In terms of the idea of brokerage, we found it very helpful to think of it as a series of tasks and functions that need to be carried out rather than a role that any one individual can carry out and, also, to make the systems as straightforward as possible. Often it serves people’s interests to create an industry around brokerage. There is a danger that you could make the whole process so complicated and planning so difficult: “That is something that I can do and needs to be paid for”. One of the things in terms of opening out control needs to be where people themselves or their family members want to help people sit down and figure out, “How do I use a personal budget to achieve the outcomes that I want to in my life?” that there are systems there in terms of information and there are things there that people can draw on and can use. Rather than thinking of brokerage as something that has to be done by paid professionals, there are questions to be asked around how do we make the whole process as easy to navigate as possible, and then, when people themselves (and we see lots of examples of this) have sat down and developed a support plan, they often think, “I want to help somebody else”, and the idea of peer support and enabling people and organisations to support each other around some of these aspects of brokerage.

Professor Beresford: I would want to add to that. I think that John is right to caution us against the over-professionalisation of the role of service broker, but if we go back to comments that have come from several of us, being able to make meaningful choices, being able to give informed consent can be very difficult when you have no track record and experience of doing that in relation perhaps to a crisis, a changed circumstance in your life and the need to turn to social care. I would refer people to the work that has been undertaken by the National Development Team for Inclusion, who have given a lot of very careful thought to the role of service brokerage, for example; and I think what they and I would agree with is that we need to have service brokers who are not over-professionalised but who are skilled and qualified—we need some form of qualification—and who are independent, and that needs to be accommodated in costings. One of the points that they have made is that the management of such independent service brokers should very much be including people who come from service user perspectives and service user organisations. I think that would offer a real corrective to over-professionalisation, but, whatever we call it, people will need some kind of help in getting the best out of new arrangements for choice and control.

Professor Glendinning: I would add two points to that. First, I think it is important not just to think about the initial sets of choices around services but it is about ongoing support, ongoing support as your condition changes. As your needs change, you may want to make changes in the services and kinds of support arrangements that you have. So I think people need ongoing support; it is not just that initial thing. The second point is your point about the expertise that brokers have. I think that achieving good professional brokerage or advice services requires financial stability, and I think it does require investment by local authorities.
Q792 Dr Taylor: Peter in “What Service Users Want” you say that direct payments should not be “framed in narrow consumerist terms of individualised purchase of care.” You are just getting at the flexibility that we need with that, are you not?  
Professor Beresford: Partly, but I think we need to accept that having help when things are difficult to be able to live your life under what may be changed circumstances is not the same as buying a fridge or going on holiday. It really is not. Of course when you do go on holiday and you do buy a fridge, there are set up quite a few systems and organisations to safeguard and protect you. The whole crux of this is about enabling empowerment in a meaningful way, so that you could take back control over your life. One of the wonderful things about good social care, whether we are talking about people at end of life or when they have sustained through onset of impairment, mental or physical, some major change, is the way that it can enable people to make the very most of their life and have a positive life, and that is not, again, like buying a fridge or buying a holiday. You need help, you need support, as well as the flexibility you have just mentioned.

Q793 Dr Taylor: But empowerment is vital.  
Professor Beresford: In a meaningful way, yes.

Q794 Dr Taylor: Steve Cohen wrote an article in Community Care magazine: “Personal budgets remove choice.” What do you make of that?  
Professor Beresford: I wonder where Steve Cohen is coming from. I think the Government is getting it right. The Government started off with a bit of a preoccupation with means, and now, because it is talking much more not only about individual personal budgets but about personalisation, it is talking about goals and desired ends, and that is what it has to be. It is a weird word “personalisation.” As I heard someone say the other day, it has taken us until the 21st century for social care to realise it is about human beings and enabling it to be in accordance with their unique rights and needs, but the truth of the matter is that we do have the potential for more change if we see this as a whole spectrum—Caroline has emphasised that—of different ways that you can get what will work best for you to maintain your unique aims in your life but your shared rights in our society.

Q795 Dr Taylor: And goals and ends are the crucial, important things.  
Professor Beresford: Get the goals right, get the outcomes in your head, and let us spend a little less time just looking at technicalities.

Q796 Stephen Hesford: Should the Vetting and Barring system apply to personal assistants? Should PAs be regulated? If they should, how would it work?  
Mr Waters: As Peter says, if you are taking control, you are making decisions in your life, there is a range of systems, are there not, that we can put in place to regulate the service we are getting? The key thing here would be in terms of access to that information and how you make it feasible that an individual who chooses to invite somebody into their life—because effectively that is what you are doing when you are acquiring a personal assistant—has appropriate and ready access to relevant information. It is a relevant safeguard.

Professor Beresford: I was interested in the comments that I think Caroline made about the Dutch experience, about making sure that there are in place the usual sorts of control and regulatory arrangements that there would be for any kind of employment. I know that service users have big qualms, and have long had, about simplistic assumptions that regulating and registering of personal assistants will sort it all out. They worry that it will be registered and regulated in accordance with old-style approaches to supporting people rather than regulated and registered in accordance with what they want out of personal assistants. But something sticks in my mind from being a member of the Commission in Hampshire: one service user who gave evidence, who also supported many other people in relation to PAs, said, “I have to say the fact that someone has been CRB checked and had all sorts of other kinds of formal acknowledgement never convinces me and has never worked. What really works for me is my gut feeling about them as a human being.” We are talking about very complicated judgments here. If we make sure that we have an occupation that is better understood, better valued and better rewarded, we are more likely to get a better quality of person doing it and then we might want to review, in association with service users, what kind of regulation and what kind of registration.

Q797 Stephen Hesford: You are arguing, in some ways, for a sort of free-for-all kind of anarchy, because there would be potentially no control over people’s exercise of whim. It would all be down to some personal whim of a user, and the system on each and every occasion would have to respond to that and would have no defence to it. That seems to be to be the logic of what you are saying, Peter. We have heard about councils running banks of PAs and having lists of preferred providers for people with personal budgets. Logically, from what you say, that would be just rubbish, because people’s gut reaction could completely cut across that, even if it was some kind of attempt to make the system work.

Professor Beresford: When it comes down to who we would want to have involved in our life, undertaking personal and intimate tasks, it will be down to the most sensitive kinds of choice, and I am not suggesting that. I have heard people say who use personal assistants that they are concerned about systems of regulation and registration giving people a false sense of security. I also know of service user organisations who operate and support direct payment schemes which have developed the equivalent of banks of PAs because there can be problems when people are having holidays or people get ill. You need more systemic arrangements which we do not have yet. We are at early days still for

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1 Guardian, 23 March 2005
personal assistants. It is a massively expanding occupation. We need to put in place—and I think the National Skills Academy is doing work just along those lines—standards for quality, principles for practice. One of the really good things about the work that the Skills Academy is doing is that it is concerning itself with both the concerns and interests of the employer (the individual service user) and the employee. It is no good—and I think it would fall into the trap you are highlighting—to be concerned only with the rights of one. There must be rights for personal assistants, just as there must be right for personal employers, but we are not there yet. That is the point. Just thinking that if you have people on a list, if you have some sort of GSCC registration, people are saying that is not going to be enough.

**Professor Glendinning:** We also need to think that personal assistants are only a part of the social care workforce even under personalisation. There are still, and will continue to be, very large numbers of care workers who work for agencies as well. We have to be careful that we do not concentrate on the personal assistant end and allow some of the provider agencies to become destabilised. They are having to respond to very different kinds of market situations, and some people will prefer an agency because they will see that as offering greater protection than being an individual employer. We also need to think about the other areas, ways in which people seek and obtain social care support.

**Mr Waters:** Very practically, that range of options can increase choice. As Peter says, if you take the role as an employer directly, you have responsibilities. This is not all about rights; it is about responsibilities and you are tied into that. As an employer, if you choose to draw your support from an agency, then you have potentially greater flexibility in saying, “We didn’t quite get on, I would like my support from another person, please,” so that keeps that choice open. In terms of the idea of preferred provider lists, an interesting question arises, to which I think Peter was alluding, in terms of saying, “Whose preferences are these?” in the measures that local authority commissioners use to assess the quality of those providers and how we listen to the experiences and voices of people who need support in that process and then share that out appropriately. One of the areas of innovation that we are taking forward with a number of local authorities is exploring a form of eBay for social care, where there is a reporting system where people can vend a rate and people can draw down and offer comments back. A range of options here give different levels of choice to people, but at the end of the day we really need to figure how we listen to people and how we share that information and make use of some of the developments in technology that open up those opportunities to us.

**Q798 Charlotte Atkins:** Thank you very much for that. That ends the session. Thank you very much for coming along. It has been a very interesting session this morning. Thank you very much for helping us with our inquiry.

**Witnesses:** Ms Jenny Owen, President, Association of Directors of Adult Social Services, and Councillor Sir Jeremy Beecham, Vice-Chairman, Local Government Association, gave evidence.

**Q799 Charlotte Atkins:** Good morning. Welcome to our sixth session of our inquiry into social care. Could you for the record give us your name and current position you hold, please?

**Ms Owen:** My name is Jenny Owen. I am the President of the Association of Directors of Adult Social Services and the Director of Adult Health & Community Wellbeing at Essex County Council.

**Councillor Sir Jeremy Beecham:** Jeremy Beecham, Vice Chairman of the local Government Association.

**Q800 Charlotte Atkins:** Thank you. You both say in your memos that social care is underfunded. How much is it underfunded and how do you calculate that?

**Councillor Sir Jeremy Beecham:** We can start with Alan Johnson’s prediction that by 2020 there will be a £6 billion gap in funding. That was predicated on the current level of needs, but as we all know demography and medical advances are likely to increase that. Another way of looking at it is that an LSE study forecasts that we need over 3% real terms growth every year to keep pace with those trends. There does seem to be a very significant gap, and of course that covers both the health and adult social care services provision within local government.

**Q801 Charlotte Atkins:** What proportion of local government spending currently goes on social care?

**Councillor Sir Jeremy Beecham:** It partly depends on how you define local government spending. Taking the totality it is about 13% but it is a much higher proportion of what local authorities have discretion over because within the total expenditure there are vast amounts of direct grants, particularly in education. Adult services in social care would be the largest item in the expenditure of most upper tier authorities (unitary and county authorities) by a considerable margin.

**Q802 Charlotte Atkins:** Obviously you will have heard that the state of public finances are going to be heading into tough times. What will that mean in terms of preparations for budgets for social care?

**Councillor Sir Jeremy Beecham:** In any event councils are having to, and are succeeding, in generating efficiency savings. Many councils are re-engineering the way that services are provided, including adult care services. One of the necessary
features to bear in mind here is that we have to move to a more “whole systems” approach, so we have to look at both health expenditure on social care and local authority adult services expenditure. Local authority adult services expenditure is only about one-seventh of the NHS total budget. In addition however, to, as it were, direct provision through adult services, local authorities also of course support a range of services which impinge substantially upon the clients in question. Whether that is housing, leisure, transport or education, there is a range of services which apply to that group, and of course that group itself is two-thirds people of pensionable age like me and one-third of younger people, so it is a very diverse population that we are looking at.

Q803 Charlotte Atkins: Jenny, would you like to come in.

Ms Owen: I would obviously agree with that, but perhaps I could add a couple of points. First, the Green Paper The Future of Care and Support talks about a £5 billion funding gap that we are going to be looking at in the future, and I think it is important to state not what the funding gap looks like now but thinking about what we are going to be heading into with the big demographic changes that are clearly coming into place. £5 billion is a round figure, a big figure, so look at that. In terms of the local authorities funding of social care, it is also worth noting how much of that can come from local council tax. There is a big variation but, on average, 39% of social care costs are funded by local government through council tax, and in some places it is up to 80%, so there is a significant amount of money that comes from local funding, from local taxation. Your final point was about how we are managing with the economic downturn and the squeeze on budgets.

Q804 Charlotte Atkins: Yes, the preparations you are making for the tough times ahead in social care budgets.

Ms Owen: I know from my colleagues nationally, colleague directors across the county, that we are all looking at very significant budget gaps between what we are looking at and what the current costs are, and looking at the demographic pressures. There are very significant gaps that we need to be managing and there is a whole range of activities going on in looking at every bit of efficiency that we can find, looking at how we can do things differently, integration, taking money from back-office costs, lots of work which is broadly labelled “Transformation activity” but which is really trying to do things in a more cost-effective way, because there are very significant concerns about that.

Q805 Charlotte Atkins: You were talking about a big variation across councils for the cost of social care. What is that down to?

Ms Owen: I was talking about the very big variation between the costs that are funded through local council tax. There is a number of reason for the variation in terms of costs between councils. Clearly there are differences between regional variations, the costs in the market, the costs that you have to provide care, the amount of costs for staffing and wages and so on, and we know there is a very big variation between how we spend our money.

Councillor Sir Jeremy Beecham: There is a slightly worrying trend in terms of commissioning, because there is a temptation in commissioning to look to reduce the costs of, for example, domiciliary services. I know in my own authority significant moves have been made there and the outcome of that is that the outsourced staff are being paid at or just above minimum wage to quite a significant degree less than they would have enjoyed with the local authority, and it does raise questions about workforce planning and whether you can attract and retain people with the right skills. That is a concern, but councils are often being driven in that direction.

Charlotte Atkins: Thank you.

Q806 Stephen Hesford: The Green Papers sets out funding options. Which, if any, do you favour?

Councillor Sir Jeremy Beecham: The LGA does not have a position on which of the options it favours, but personally I lean towards the compulsory insurance model. We have not really taken a view about at. Our prime concern is that which Jenny and I have both touched on, pointed to by the Chairman, which is the totality of funding.

Q807 Stephen Hesford: Can I ask why the LGA does not have a position?

Councillor Sir Jeremy Beecham: Because our concern is primarily about the totality of the funding. There will be further debate about how it is to be provided. For us, the main thing is to ensure that the quantum is right, and particularly, as I say, that we look at the whole systems approach, which involves the NHS funding. One of the great gains in the proposals around free personal care, about which there are of course still numerous questions to be answered, is that this does get the NHS firmly into the game of effective partnership with local councils in a way that perhaps we have not seen since joint finance projects expired sometime in the 1980s, I think it was. It has not really happened to a significant extent since then and it is potentially a very important step forward. After that, how it is funded of course, in terms of the balance between tax and contributions, is a wider issue, but from the service perspective, the crucial thing is to get that effective partnership and NHS resource into the provision.

Q808 Stephen Hesford: Jenny, which model?

Ms Owen: ADASS does not want to rule out entirely the tax-funded option. We thought it was ruled out too soon and that it needs a bit more looking at.

Q809 Stephen Hesford: Are you lobbying us to put that back in?

Ms Owen: I think it should be looked at again and not be dismissed. If, once you have done that, you dismiss it and it is a range of the other options, the most important thing for us is that enough money
gets in the system, and the model that we think will get enough money in the system is the comprehensive insurance model. That is what we are supporting, for that reason.

Ms Owen: What would your response to that be?

Q810 Mr Scott: The Green Paper proposes either a fully national model or a part local/part national model. What would your response to that be?

Ms Owen: You are not quite touching on this, but perhaps I could first of all say that we absolutely support the notion of a national assessment, the portability of assessments. That is one part of a national system: that if you have an assessment it should be consistent nationally and people should be able to move with it.

Q811 Mr Scott: That is the next question. We will be coming to that.

Ms Owen: Okay. On the second part, which is about how the funding should be delivered—Should it be nationally determined? How much money there should be for that assessment? Should it be locally determined?—we have a position here where you can see the advantages and disadvantage of both systems. We are saying that there are significant advantages in having a part local system. As I was just saying, in some places 80% of social care is funded through local government tax. There is a democratic accountability. You can tie it in and work closely with your partners in the locality; you can work closely with the NHS, primary care trusts, GPs; you can work very closely with other services provided by councils that are really important to people's lives: transport, universal services and all of those things. It is very hard if you do not have that locally driven. However, we know that a lot of people find this inconsistency between what you get in one place and what you get in another, what you are allocated in terms of the funding, is very difficult. We would say that if the Government was going to introduce a national system of funding—so that there would be this amount of money, an entitlement, and it would be nationally determined—then the risk about how affordable that is should be held nationally. We have seen this before, in the past, around residential care and social security payments. Local government is very good at getting a finite budget, a determined amount of cash and working within that budget. We take the risk of demands and the amount of money not working terribly well—the demands are much more than the money we have—and we try to make that pot work. If you have a national funding entitlement, then there is a risk that the control of that money is nationally held.

Q812 Mr Scott: Would it not be, at the moment, that there could be accusations, depending on where you are in the country, that it is a postcode lottery.

Ms Owen: Yes.

Q813 Mr Scott: You will get a great service on one side of the high street and not such a great service on the other side because it is a different council. A national system would in theory stop that, would it not?

Ms Owen: That is exactly what people say and what they do not like about a locally determined level of funding, because it will be different. That is absolutely clear. However, nationally there is a level of funding available, and the costs escalate. The costs of residential care funding, because it was held nationally, escalated over ten years tenfold because there was no cap on it. It is a very interesting question that the Government are considering doing this again. There is an issue about that. However, on the other hand, there is another issue which it is important to consider. It is not just the funding that would go into somebody's personal budget or their care allowance, you also have to provide funding for preventative work, for those universal services that need to be delivered locally. I think it is quite a complex system when you start thinking about national.

Q814 Mr Scott: Sir Jeremy, what in your view would be an ideal balance between local and national funding?

Councillor Sir Jeremy Beecham: The concept is best described by looking at a national care guarantee rather than talking about a national care service, so that you have that basic entitlement wherever you are. How it is delivered will depend on local circumstances and local choice, of course reinforced by local accountability. After all, we have had the National Health Service for 60 years and, arguably, we have not eliminated the postcode lottery there. Sometimes I have been tempted to form a society for the preservation of the postcode lottery because I do think you have to respect local differences, not only in demand but how you meet that demand, and so you need a system which is flexible enough to allow you to engage with other partners, the third sector perhaps, in particular, to commission appropriately and to offer choice. You cannot do that in a monolithic bureaucratic structure, so you do need to have the framework of a national care guarantee and then that is delivered locally. As to the balance of funding, there is an issue here too, because if the funding were to go national, that would have a significant effect on the gearing that would affect local authorities. Already it is 75% central funding/25% local funding, so a 1% increase in a council's expenditure translates at the moment, on that gearing, into a 4% increase in council tax. The more you push towards the centre, the greater the impact on local council tax of any other decisions that you might be making, including those on services which are not within that national funding: housing, transport and the other things that Jenny and I have both referred to. There is an additional potential downside to, as it were, nationalising the funding in the way that has, for example, happened to the funding of schools, but I do not want to reopen that.
particular argument. The system, basically, would be a national care guarantee, locally delivered, locally accountable, and based very much on local authorities working in partnership with NHS, carers and third sector and, indeed, private sector organisations.

**Q815 Dr Taylor:** Before I move on, I am delighted to hear you say, Jenny, that the tax-funded option should perhaps remain. That was very much the message from our previous witnesses. They disagreed with the assumption that we cannot ask for more cash from the working age principle, provided people can trust that they will get help when they need it, which I thought was absolutely crucial. To move on to the nationally-uniform assessment, ADASS says that “The Single Assessment process has not been fully embedded across the Health and Social Care System and needs to be in order to underpin [this] agenda.” Why will a new model work when this has been in place since 2001?

**Ms Owen:** The Single Assessment System is a single assessment across health and social care. Although there were different models that you could use, you would work on your single assessment in every locality between health and social care. It was not a single national assessment that worked across the country; it was different in every place, depending on what kind of system you used and the basis for it. The reasons that single assessment between health and social care has not worked very well across the country are many and varied but one of them is not having compatible IT systems. We still do not have IT systems that talk to each other.

**Q816 Dr Taylor:** As basic as that.

**Ms Owen:** It is really basic stuff, yes. There is a specific thing about that, but the principle about having a single assessment linked to a national assessment really is the same. If you have a national assessment, you agree that assessment criteria. You are still going to have people completing that assessment, and those assessments are between the social care professional and the individual. You would not have a scientific absolute correlation—and I cannot believe that will ever be the case—but you can create a national assessment system where the same questions, the same criteria are used, in the same way across the country. It was not a single national assessment that worked across the country; it was different in every place, depending on what kind of system you used and the basis for it. The reasons that single assessment between health and social care has not worked very well across the country are many and varied but one of them is not having compatible IT systems. We still do not have IT systems that talk to each other.

**Q817 Dr Taylor:** Do you see computer systems becoming compatible at any time?

**Ms Owen:** Between health and social care?

**Q818 Dr Taylor:** Yes.

**Ms Owen:** I hope before I die!

**Q819 Dr Taylor:** Presumably you would be in favour of something this Committee has suggested for a long time, that there should be some merging of social care and health budgets.

**Ms Owen:** I think we all would agree there must be greater integration of working between health and social care. How that looks? I do not favour, personally, just structural solutions—I think it is more complicated than that—but greater integrated working and the systems and processes that underpin that are important.

**Q820 Dr Taylor:** Sir Jeremy, I think you said there was an argument for local differences but surely the same package of care should be guaranteed wherever you are in the country, should it not?

**Councillor Sir Jeremy Beecham:** No. The same basic entitlement to care should be guaranteed wherever you are, but it would be wrong to preclude the possibility of going above that level. You must have discretion to do that and also to innovate. I do not think you can simply lay down one model of care across the country. Certainly in my time, long ago, as Chairman of Social Services in Newcastle, we very substantially improved the range of services at that time. We had the discretion to do it and we did it. I would love to see local government doing that under a new system, but based on that very firm bedrock of basic entitlement. But you have to be able to deal with the situation that presents in your own locality. An inner city area is different from a rural area in terms of both needs and how delivery might be affected, for example; different social composition and ethnic groups and so on will have different problems. You cannot have a simple universal rule, particularly one which would be regarded as a maximum.

**Dr Taylor:** I think you are right to use the word “entitlement” because in the first session “flexibility” was a word that came up very often. Thank you.

**Q821 Dr Naysmith:** Good morning, Jeremy. Welcome to the Health Select Committee. It is good to see you again. The Queen’s Speech included the policy of providing free personal care at home for those with the greatest needs. Do you think this policy has been properly costed and evaluated?

**Councillor Sir Jeremy Beecham:** It remains to be seen. On the face of it, it looks as though the estimates may be fairly crude. They depend very much, of course, on precisely what is covered by the pledge, and there is some guidance. We are talking about critical needs. Most authorities have unfortunately had to pull back to that kind of level anyway under the financial pressures that have been experienced, but there is potentially scope for argument about what those measures would involve in terms of the care that would be available. I rather fear, speaking as a lawyer, that some of my professional brethren will be rolling up their sleeves with the prospect of judicially reviewing councils’ decisions or whoever’s decisions on how that is to be met. The costings and the numbers, I would say, are not robust necessarily. I am not saying they are definitely not right, but there must be a suspicion, given the short timescale in which all this has been developed, that the figures are not particularly robust. The estimated figure of £670 million may or may not be right, but it is really too early to say.
Q822 Dr Naysmith: The suggestion is that councils will have to find £250 million in efficiency savings. Is this feasible? **Councillor Sir Jeremy Beecham:** We are already finding substantial efficiency savings. We would be finding those anyway, but there is something called the new burdens doctrine, which is a basic agreement between government and local government that, if new responsibilities are placed upon local government, local government will not be required to meet those out of its existing resources but that extra funding will be provided. One approach is to look at whether some of the other burdens that councils have to cope with can be relieved. The LGA has submitted some suggestions of around £700 million a year of other burdens which could be lifted from us, which would free up money to contribute towards this, whether it is £250 million or more. That seems to me reasonable. In other words, there would be efficiency savings, but they would be efficiency savings generated from reducing the superstructure of very largely otiose regulation and inspection, but other things as well, which government require to be carried out at the moment. I am saying that the £250 million should not come from current council activities, because already we are making efficiency savings of that kind. A burden of this kind has to be funded either directly by government’s intervention or by reducing other burdens on us.

Q823 Dr Naysmith: Another suspicion that people have is that there could be a lot more demand than the Government expects. Do you think that is true? **Councillor Sir Jeremy Beecham:** That may well be true. Of course, once you create the concept of free personal care—as Scotland have found, I think—it becomes difficult to turn people away who may feel that they qualify or who may want rather more than what may be a pretty basic provision in terms of personal care and personal hygiene or oral care or whatever, and things like companionship or shopping or help with household chores and so on may be very limited. It is opening up a bit of a Pandora’s Box. Having said that, the concept of helping people stay in their home, contrary to the views of our political colleague Lord Lipsey, does seem to me right. The principle is a good one, but I am not yet confident and I do not think the LGA as a whole is confident that the figures necessarily represent the likely cost of this at this stage.

Q824 Dr Naysmith: Could councils just end up increasing rationing and charging in respect of some of the other things that you have just mentioned? **Councillor Sir Jeremy Beecham:** If we do not get the resource one way or another externally, then such councils as are still providing care for less than the critical group and charging of course is already an issue in a number of places. I am not saying that we necessarily will get into the Barnet “easy council” system, which may provide a basic service and then anything else is charged for, but councils will be obviously over the next few years under great pressure. There must be some risk of what you have described happening.

Q825 Dr Naysmith: Jenny, I covered a lot of ground there. Do you want to comment on any of those things? **Ms Owen:** I will come back to the question of whether the modelling is robust. Of course it would be good to ask those people who did the modelling for the Department of Health. I am sure there was a range from low to high.

Q826 Dr Naysmith: I think our advisers are listening. **Ms Owen:** Yes, it would be very interesting for them to be able to say. It may well be that the figures picked were at the lower end of the modelling and it would be interesting for you to know that. In terms of ADASS’s position on this, we wrote to the secretary of state soon after it was announced and said we were very concerned, and there were a number of reasons for concern about the financial costs of this. One is that there are a number of people who are self-funding at the moment and I do not think we have any idea how many self-funders will come and say, “I want to apply for free personal care.” It is very difficult to assess that and there could be many more people than the Government modelled. There will be a number of people who switch who are currently having personal care at home and they are being looked after by families and so on who will come into the system. It is again difficult to know. Some people who have very high levels of need, much more expensive than residential care, in fact, could well come and say that they want to be entitled. The second big area of concern—and I think even the biggest area for me—is the administrative burden. We have been trying through the work we have been doing on personalising social care, to take money out of bureaucratic systems and processes and free up more money to put into the care pots, and this takes us back into a fairly heavy administrative system. At the moment most of us would not be able to tell between people who had critical and substantial needs, so we would have to invest in systems that absolutely defined those only in the highest bands of need. We would then have to assess people on the four activities of daily living, if you look at the current guidance on how this is going to be applied, and there will then need to be, as Jeremy has said, a whole plethora of work to ensure that those judgments are robust because they will be challenged. There will be legal challenge. This is the next level down of people below continuing care, and we have all seen how difficult it is for people who want a challenge, believe they are entitled to continuing care, cannot understand why they are not entitled to it, and it is jolly hard to work your way through that system. This is now creating a system that is the next level down. Administrative burden is going to be very high. In terms of efficiencies, the very first question we were asked by the Chairman was how we are going to be managing in the economic downturn with the pressure on budgets. We already have efficiencies in our system, as Jeremy
said. It is not a question of being able easily to find others. The budgets of course for next year were already set, so over and above that we are opening the books again and looking for additional savings that could be made. We are very pleased there is some Department of Health or NHS money coming into the social care pots, but there are real, significant risks around making this work.

Q827 Dr Naysmith: I was interested particularly when you suggested that it might be more expensive to care for some people at home than in residential care.

Ms Owen: Yes.

Q828 Dr Naysmith: Do you think there is a danger of bouncing people into residential care to avoid paying for free personal care at home?

Ms Owen: This is a really difficult question. Local authorities have two duties. One is to assess need and provide care and support to meet that need, and the other is to have a duty of value for money, to get care at the best value. When you look at the judgments that have been made, we absolutely have both those duties. If your care, the same sort of good quality care, can be provided at better value in residential care, you have a real dilemma. It is very difficult.

Q829 Dr Naysmith: Irrespective of what Lord Lipsey says, Jeremy, what do you think?

Councillor Sir Jeremy Beecham: Quite. I agree entirely with that. I am not at all convinced by Lord Lipsey's argument. I would just like to refer to the impact analysis that the Government has published about this. It is candid enough to talk about "inherent uncertainty" in estimating the costs, which is why they have only done it for two and a half years in terms of the free personal care. I do not know how they have done it, but they have estimated the cost of re-ablement, which is increasingly part of the development of adult care these days, at £1,000 a person. I do not know on what basis that has been brought forward or how many people receive this and, indeed, how many then leave the system having been re-abled, as it were, or how many may need further care. There are very big questions about all of this. I suppose in an ideal world you would pilot this first and see what it costs, but then we have said that so many times and for so many different policies over the years but it does not ever seem to catch on.

Q830 Dr Naysmith: It is one of the regular recommendations from this Committee whenever we report on almost everything.

Councillor Sir Jeremy Beecham: Exactly.

Q831 Dr Naysmith: Will you please evaluate the pilot studies. They are being rolled out all over the place without evaluating them.

Councillor Sir Jeremy Beecham: Yes.

Dr Naysmith: Thank you very much.

Q832 Dr Taylor: Doug and I were both at the meeting where Lord Lipsey made his comments. It was interesting that in, I think, the first session we had here after that, that several of our witnesses did agree that they were absolutely amazed that this proposal had come just at the moment when we were talking about the Green Paper. Would you agree with that amazement or do you think it was appropriate?

Councillor Sir Jeremy Beecham: I think a modest amount of astonishment was probably felt in the Department of Health actually! So, yes, I suppose I would.

Q833 Dr Taylor: Thank you. We have really covered the draft regulations that have come out. I do take your point, Jenny, that it is going to be critical people with critical needs and these are going to be the most expensive of the lot. Are there any other comments about the draft regulations and guidance that you would like to make?

Ms Owen: We have said to the Department of Health we will work with them—because obviously we are in a consultation period on the regulations—and we will look at them in detail and try to work on a system, given that this is going to go through and become law. If this is a law, we have to look at what is the most effective way of making this work. I have to say that the four activities of daily living I think could wrap us up forever in arguments about what does it mean. This is the experience of Scotland. Let us just take one example: Help with eating. What does it mean? Does it mean cutting up the food? Does it mean help with putting the food in your mouth? Does it mean microwaving it? Does it mean cooking it? For lawyers, as Jeremy said, this is going to be an absolute minefield. I am also very concerned because we have spent the last four or five years, at least, trying to get continuing care to work well, and there has been now the second lot of guidance around how to improve the assessments around continuing care. I would like to see something that tries to learn from the experience of that, not to get us into a situation that recreates all of those difficulties. The other thing is that we have been spending the last two years working on personalising services, getting away from: "If you need this activity of daily living, then you need this" but having much more flexibility around the response. We must not throw out the personalisation of our services as we have to start looking at this.

Q834 Dr Taylor: You have already hinted at the absolutely vast expense that this could be. I think you picked on the self-funders. We do not know how many there are of those.

Ms Owen: We do not.

Q835 Dr Taylor: Is there any way of estimating the proportion of existing service users who would qualify for free personal care?

Councillor Sir Jeremy Beecham: The Government has produced some suspiciously precise estimates. The figure that they have come up with on self-funding and unmet need is £46,089. Residential care switches: £2,384. I just do not know where these figures come from.
Dr Taylor: Thank you very much for pointing that out. That increases our enjoyment

Q836 Mr Scott: Sir Jeremy, we have heard a lot recently of evidence and allegations of poor quality of social care. Is what we have heard about the exception to the rule? Is it the fault of councils? Is it possibly down to tendering and the lowest bidder getting the contract?

Councillor Sir Jeremy Beecham: We need to keep today’s news—on which perhaps your question is partly based—in perspective. Most social services authorities are good or excellent. Eight are adequate. The poor are no longer with us, so to speak. I think Jenny said to me before, “Adequate is the new poor.” Perhaps we need to consult the editors of the OED about that. Obviously a service which is not good enough is not acceptable, but only eight councils’ services are described as “adequate”. Equally on the residential care side, *The Times* ran this scare story this morning about people living in squalid homes and so on. That would be entirely unacceptable. The numbers they talk about are 10,000 out of 440,000 people in care. 10,000 if they are not living in decent accommodation is 10,000 too many, but, again, it is a miniscule percentage. I do think there is a continuing challenge to authorities and the Care Quality Commission to ensure that standards are maintained and improved, but the general level is more than acceptable, it is good or excellent. In terms of the different providers—to come back to your outsourcing point—the figure is 87% of local authority residential places are regarded as excellent, 86% of third sector providers, and 74% of private providers. That is lower than the other two, although, as Jenny helpfully pointed out here this morning, it has increased from 64% last year, so it is on an upward trend. I do think there is a question about some of the outsourcing. I touched on it indirectly before, and there was of course that interesting television programme—and I cannot remember whether it was *Dispatches* or *Panorama*—in which they had somebody with a camera working in one of these organisations. It was worrying, because you do need properly paid, properly trained and properly supported people delivering care of this kind, and there is a danger, in the drive to keep down costs, in my view, that you can end up with the cheapest but not necessarily the best. There is another danger of a different kind slightly, which is in the provision of residential care. There was a huge shift to outsourcing this in the 1980s, with a very unlevel playing field in terms of the grant that was available, and many local authorities effectively withdrew from residential care provision which was left in the hands of, largely, the private sector, and then of course it became uneconomic for the private sector and there were capital gains to be made out of disposal and so on, and so you were left with contracting provision. I think you need a mixed economy of care across which standards should be maintained by proper inspection, and I would draw attention to the possibilities, both in that context and generally, of enhancing the effectiveness of scrutiny within local councils, including the participation of third sector people, carers and the like, in the scrutiny process. That is potentially a powerful tool to back up the statutory regulation.

Q837 Mr Scott: Thank you. Jenny would you like to add anything?

Ms Owen: Yes, I would. I would like to make reference to the headline news as we woke up this morning. There are two reports that the Care Quality Commission have published this morning. The first one is about the performance of local authorities. Now we know that it was the wettest November ever since records began. Today, since records began, the performance in local authorities is the best ever. There are now no poor councils for the first time ever and 95% of councils are good or excellent. That should have been the headline but it was not. There are eight adequate councils. If CQC were very worried about that performance, there would have been some very significant work going on between the Care Quality Commission and those local authorities from the time that they were assessed in that way, which was back in the summer, and now, and that absolutely has not been the case in most of those councils. I think there is a bit of an issue there which I will just park. The bigger question was about the quality of the care provision. As Jeremy said, it has varied depending on the type of provider. It raises questions about the commissioning of local authorities. They commission just under half of the places in the country; the other half is paid for by people who are self-funders. Obviously, whether you pay yourself or whether you are paid for by the local authority, the quality of those homes and the home care is incredibly important. I directly asked the question of CQC: “Should we stop commissioning places in those poor and adequate homes?” Of course the answer to that has to be, “No, you cannot say that. You must not stop, because there is a whole series of reasons and complexities about this.” For a start, homes go in and out of these ratings. One of the main reasons why homes go in and out of ratings is because they might lose their home manager or the domiciliary care manager, and the manager has a very big impact on the quality, and it can be temporary. The job of the local authority is not to stop commissioning those places, it is to work with that home to bring the standards back up again. Let us take, for example, a residential care home with 90 residents. You cannot have 90 residents moving out of a home—and this would happen very frequently with the ratings going up and down. It would not be what residents want, it would not be what their families want, and it would not be the best way to run a system. We have to work on improvement. Some of that is about our workforce development. Sometimes we help put managers alongside, sometimes we look with the providers to see whether they have a good manager somewhere else. There is an enormous amount of detailed work that goes into improving the performance in residential care and domiciliary care services. As well as that, there could be reasons why somebody has chosen an average rated home: because that is closer to where their son/
Councillor Sir Jeremy Beecham: It will partly depend on our partners locally, early, frankly, to say how much of a cost that is going to be. It will partly depend on our partners locally, and this will vary from place to place as well. Where you have a strong third sector, a strong Age Concern, for example—and I declare an interest as the honorary president of Newcastle Age Concern—organisations like that will be able to help people but to be providers as well. That will be important. That then raises a question about the relationship with the third sector. Again that will come under financial pressure from local government, and it may be that central government is going to have to look again at whether extra provision needs to be made to strengthen the role of the third sector in that respect.

Q838 Mr Scott: It is a great shame that people do not use language that everyone understands.

Ms Owen: CQC CRILL data is very recent in the scale of data returns and it is now what we can work with. The thing that will work most effectively is when councils and CQC can work together, look at that data, understand what it means and the questions we need to ask, and then a programme of work with those authorities. I think the scary headlines today belie the significant amount of work that is going on.

Mr Scott: Thank you.

Q839 Stephen Hesford: Jeff Jerome, the National Director for Social Care Transformation, came to tell us what he is doing, a sort of parallel system on personalisation and the transformation agenda. How are councils doing?

Councillor Sir Jeremy Beecham: I think personalisation is being developed. We are moving on from direct payments—which are, I guess, one potential aspect of that. As Members of the Committee heard earlier from the previous witnesses, there are a number of aspects to that, including the need for authorities to help people navigate the new systems. Whilst taking the point that one needs to avoid over bureaucratising it, it does necessarily involve, to a degree, first of all trying to establish that there is a market there and encouraging providers, whether it be a local authority itself or third sector or private sector providers, and quality assuring what is available, and then helping people make the choices that will suit them best and securing some value for money. It is relatively early days but it is beginning to develop in most authorities. I suspect it will not be too long before we see Daily Mail headlines, as there has already been one case when some chop got a season ticket to see Rochdale Football Club as part of his personal care package. It might have been thought to have been depressing rather than otherwise, but apparently it was not.

Q840 Stephen Hesford: You are not a Rochdale fan.

Councillor Sir Jeremy Beecham: I do not know that there are many Rochdale fans—except for this chap. We are going to have that kind of debate. I think, about what people choose to spend their money on. Councils will have to help people, but will clearly not be deciding for them. There is a cost to that. It is too early, frankly, to say how much of a cost that is going to be. It will partly depend on our partners locally, and this will vary from place to place as well. Where you have a strong third sector, a strong Age Concern, for example—and I declare an interest as the honorary president of Newcastle Age Concern—organisations like that will be able to help people but to be providers as well. That will be important. That then raises a question about the relationship with the third sector. Again that will come under financial pressure from local government, and it may be that central government is going to have to look again at whether extra provision needs to be made to strengthen the role of the third sector in that respect.

Q841 Stephen Hesford: Jenny, obviously you can add anything you want to what Jeremy has said, but in terms of levers to get this thing done, what are they and how are they working?

Ms Owen: I do not recognise the parallel working question.

Q842 Stephen Hesford: It is more that Jeff Jerome’s organisation, as I understood what they told us, did not seem quite to fit. It seemed to be bolted on.

Ms Owen: Perhaps I could address that part of it as well.

Q843 Stephen Hesford: Yes. Ms Owen: Rather than seeing this as parallel activity, I see it as absolutely essential and the whole of the work that we do in local authorities at the moment in adult social care is a huge transformational programme. It is cultural change, it is process change, it is operational practices change. It is fundamental. When we brought in the community care changes in the early 1990s, that was fundamental change. This is bigger. In my view, and it will take just as long. I think that was underestimated when it started. I would say a very, very significant programme. It was set up by government as a three-year programme, funded for three years. We are halfway through, so we have some idea about progress which I will come on to. In terms of what we did in order to help the sector, one of the things that has been very, very good about the way this government policy has been implemented is that it has been done in co-production with local government. That means we have sector-led improvement, the sector driving the agenda. We set up a consortium to manage that. It consists of the Association of Directors, the LGA, and the IDEA. That group of people, with Jeff Jerome as National Director, provide leadership for us around the work. So not parallel but actually providing some leadership and driving forward. In terms of where we have got to, one of the problems we had to begin with is that one of the soundbites, one of the easy ways of describing personalisation, was “personal budgets,” but of course the changes are much more significant, much bigger than just personal budgets. They range right through from looking at prevention, looking at information, looking at market development, looking at social capital in the way our communities are organised. It has fingers in each of those areas. We did a self-assessment back in April and May, and in May we were able to set a
benchmark of the progress that had been made. We knew from that piece of work that there was progress being made in every authority. Most councils had dedicated teams to lead the transformation agenda and it was funded by the reform grant; most had active engagement with their providers and were planning for development in the markets; four out of five authorities were saying that provision had already become more flexible; 23 authorities felt that their local information services were going to provide good information, advice, potentially advocacy. When we did this survey—so the latest figure then we had was 31 March—93,000 were receiving personal budgets. We were asked to estimate how many we would have by March 2010 and that was estimated at 206,000. You can see, starting from a fairly low base, that the trajectory was fairly significant. There are big variations, everybody started from a different place, but everybody is working on an aspect of the transformation. In terms of levers, because this is co-production and we are driving the improvements ourselves, we have put our own levers in place. There was a letter that came out from the LGA and from me as President to say: “These are the milestones” and we set five milestones that we expect everybody to have achieved. I could go through those with you if you like, but they are around how you engage people, the people who use services, what you are doing around prevention, what you are doing about information and advice.

Ms Owen: I think it will be better value for money. My experience locally in Essex of having 5,000 people going through the personal budget system, of having a resource allocation, is that some people are less on the resource allocation than they would be under the old system and some people are slightly more. Overall it just about balances out. But if you are giving people first time what they believe will make a difference and meet their care and support needs, you stop throwing away meals on wheels as soon as the meals on wheels van has gone away, you stop using services that you did not really want and which were quite expensive but there was not anything else, and so you are getting a better value product. You should be saving money through that alone.

Q846 Stephen Hesford: The 5,000 of your total responsibility, the number of people accessing adult social services, what percentage does that represent?

Ms Owen: At the moment, any new referral, referred in since last October, is being offered a personal budget. Some people are taking the money. Some people are saying that they want a managed service, but it is very transparent how much that service is costing. About half the people are taking a bit of both. Overall in Essex at the moment we are supporting 24,000 people. We are going to be moving to a programme of offering up the personal budgets for existing service users but we are doing that in a managed way, because otherwise we will get all sorts of destabilisations that are quite difficult to manage.

Q847 Stephen Hesford: Is the 5,000 a good sample to give you a good idea of where this thing is going?

Ms Owen: It is giving us a very good idea of what people are choosing in their support plans, of ways in which their care and support needs can be met. Some of the most interesting things that are coming out of that are the different ways in which people’s support plans look from their old traditional care plans.

Q848 Charlotte Atkins: Jenny, could we have a copy of the letter you mentioned?

Ms Owen: The milestone letter.

Q849 Charlotte Atkins: Yes, please.

Ms Owen: Certainly.

Q850 Charlotte Atkins: I would be grateful if we could have a copy of that. I am going to move on to talk a bit about direct payments. Direct payments have been available since 1996 but the take-up has not really been very high. We are now moving very much towards individual budgets, personal budgets. Is this an attempt to repackage direct payments which in some people’s view would be seen to have failed?

Ms Owen: I think it is a bit different. Direct payments historically were aimed at younger physically disabled adults. They did not have very big take-up with older people, and so they were very much more focused I think. They were used and
allocated to help people organise their own care. The personalisation agenda is much more wide-ranging. One of the differences with personal budgets should be on what you can use it for. Direct payments were quite strictly ruled around that. There were rules about what you could use your direct payment for.

**Q851 Charlotte Atkins:** Yes, you were not able to use it for local authority services, for instance.

**Ms Owen:** No, and it was very difficult to use people who were in your close family circle and so on. This is opening all of that out. Because it is about whole system change, it is not just about repackaging direct payments. You can see from the take-up of 93,000 straightaway that it has much wider appeal. I think we now know that something like 40% of the personal budgets are going to older people. That was not the way in which direct payments were used in the past. I do not think it is just a repackaging; I think it is a transformational change.

**Q852 Charlotte Atkins:** Older people are claiming it more and younger people are continuing to do so.

**Ms Owen:** Yes.

**Q853 Charlotte Atkins:** One other thing that seems to be changing is that rather than having individual budgets which combine several funding streams, we are now moving to personal budgets involving just social care funds. Why is this happening? Why is the reason for this? Does it matter or is it just part of the transformation process?

**Ms Owen:** That is a difficult question. In Essex, I was one of the 13 pilot sites for individual budgets. The aspiration behind that was that these funding streams would come together in a much more flexible way and therefore people could bring all of those funding streams around them to look at what their terms were. It did not work. We could not get agreement for how the independent living fund would come into that, for example. It was very complicated around Supporting People money. We just did not manage to do it and it ended up, by default, being the care budget from local authorities. We hope we will be selected for a trailblazer site for the Right to Control, the Welfare Reform Agenda around welfare benefits. This is an attempt to bring different funding streams together under the control of the person for whom this funding is allocated. It requires government support for these funding streams to be used and it requires flexibility for those agencies locally to think about using it. We need to make sure that there are no blockages to this working and I very much hope that the trailblazers for Right to Control will take us further than the individual budgets did.

**Q854 Charlotte Atkins:** We are already seeing personal budgets in the NHS. Would you like to see personal budgets integrated right across health and social care?

**Ms Owen:** Yes.

**Q855 Charlotte Atkins:** I can understand you, coming from the Director of Social Services, wanting to get your hands on that big pot of money at the NHS. Inevitably, I know that at local level many local authorities think that, for instance, primary care trusts should be contributing much more towards social care budgets. Do you think you will get resistance from the NHS locally, or do you think now that local authorities are working in a much more partnership-led way with commissioning services together?

**Ms Owen:** The issue about health personal budgets we still have to play out and see how they are going to work. The pilots will help us to see that. The pilots are going to focus on people who have long-term conditions. In my authority we were going to look at one around mental health needs. We are spending money on the same people. This will not be about local authorities getting their hands on the NHS money; this will be about the NHS community services, who are currently supporting somebody, the same people we are supporting, putting that money together, so that packages can then be flexible and controlled by that individual. That will start to make a big difference. The money is already going into that person but not in a co-ordinated way.

**Councillor Sir Jeremy Beecham:** Benefit sharing is really the name of the game, is it not, as opposed to cost shunting which is a traditional feature of the relationship between local government and the NHS. It has to change and in many places it is doing so. There are doctors who are now using part of their budgets to send people on what would be regarded as leisure type activities, dancing or swimming or whatever, because it is conducive to their health. That is a more sensible view because, ultimately, that becomes a preventative measure, either preventing illness developing or certainly making it more bearable. I think there is a willingness. We are speaking largely of PCTs and what I am not sure about is the extent to which the acute sector is engaging with this agenda.

**Q856 Charlotte Atkins:** I think PCTs might agree with you.

**Ms Owen:** Interestingly, when you think about the acute sector, one of the things we know is that too many people end their lives in a hospital. They do not want to be there but the alternatives are not there to support. End of life care would be a really good example, where if you put the personal health budget and the personal budget from the local authority together, people could make choices about how to end their lives with the right care and support where they want it.

**Q857 Dr Naysmith:** Jenny, one of the risks of personalisation that we have heard about from previous witnesses is that some collective services, such as art classes or music classes or dance classes, normally held in day centres, have closed down as a
result of personalisation. You must still be running them in Essex—quite a number of them, I suspect, with the size of Essex.  

Ms Owen: Yes.

Q858 Dr Naysmith: Does it matter if that happens?  
Ms Owen: It is very difficult to say that that cannot happen. If you are giving people choice about where they want their services and they are choosing not to use the services we currently run, then I think it says something about the services that we currently run and whether they are fit for purpose. For those collective services I think there is a risk, and it is one that we are considering as we are thinking about developing the range of services.

Q859 Dr Naysmith: What can local authorities do about it?  
Ms Owen: There are two things we can do about it. One is that we must be very flexible and make sure our money is not just tied up in services so that people cannot get a choice because they cannot access the money more flexibly. The second is that, by looking at what people are choosing to do with personal budgets and listening to what people want from those services, you can re-orientate them and make sure they are exactly what people want. We have not seen, at the moment, huge numbers of people leaving our day services, but we do have some very interesting conversations going on with our services, where people are saying, “Let’s think about this. If people wanted to buy this what we would give them that is different?”

Councillor Sir Jeremy Beecham: There could be a bit of an analogy here between this area of policy and, say, parental choice in schools. The exercise of some people’s choice, which will suit them, may restrict the choice and availability of services for others. It is a difficult line to tread, I think. We have to be able to protect those who do not necessarily want to do a different thing, who may still want the day centre or luncheon club or whatever even though others may not. All we can really do then, as Jenny says, is to listen to people, listen to the organisations that represent them too, which are very often helping to make the provision, but we must protect those who are not willing or capable of making the choices that some will find easier to do. There will be a cost to that. It is part of the total costs that one has to meet.

Q860 Dr Naysmith: There are things like brokerage and advocacy and advice which are widely seen as essential to help people put together fair packages for themselves. One or two social workers have said, “This is great. It takes us back to being real proper social workers.” Is that right? Is that the role of a social worker? If not, who should be doing all these things?  
Ms Owen: That is a good question. When I was saying: “It is wholesale change.” We are now in a position in all our local authorities of thinking, “What is the role of social workers and of other people in the local authority and of other people outside the local authority, in the voluntary sector, in our user-led disability organisations? Where do these new responsibilities and roles fit.” That is why I was saying that it is big operational changes as well as just what you think about personal budgets.

Q861 Dr Naysmith: Who gives the advice in your authority when someone undertakes to go personalised?  
Ms Owen: At the moment we have a range of things. Because we were an authority that had a lot of direct payments, we have built on a service that we buy from our disability organisation, the Coalition of Disabled People in Essex, a user-led organisation which supplies our system to support those people who have set up through direct payments. We are contracting with them to provide support for people who are getting personal budgets. We also have social workers who are starting the support planning, and my question to our executive management team is: “What shall we do in the future?” What has been really interesting is having the taskforce report on the future of social work coming out yesterday, because it is helping us to start to define what really we should be using our qualified social workers to do. Where can we really use their expertise and where can we use other people? I have heard others, Peter and John who you had giving evidence this morning, talking about potentially the over-professionalisation of brokerage being a problem, but in my view it does not matter which organisation it is. There are some people—and I think user-led organisations are a good example—who, because they have been through this system, understand the nature of peer support and could offer a very good brokerage service. I do not think that would be over-professionalising it. In my view, that is probably the future but it will not happen overnight.

Q862 Dr Naysmith: You presumably are paying for it as an authority.  
Ms Owen: Yes.

Q863 Dr Naysmith: Should that come out of the payment that is made to them or should it be from council tax and local taxes?  
Ms Owen: There is an argument that if you want an ongoing social work service, that is a service, a care management service, and that is a service you should pay for. There is an argument that you could pay for a support plan. At the moment we are not charging people for a support plan. We believe that it is part of our responsibility for the authority to get right.

Q864 Dr Naysmith: Switching hats, in other authorities is it different?  
Ms Owen: With my ADASS hat on. As far as I am aware, in terms of support planning, that is not a service that has a widescale charging system of being charged through your personal budget. How it will evolve in the future if it goes into brokerage is a question we will have to look at.

Q865 Dr Naysmith: Jeremy, do you have anything to add to that?
Councillor Sir Jeremy Beecham: Not really, except that it could be counterproductive to start charging people to help them through the system. Because if they do not take the help, it may end up that something that does not suit them ultimately leads to greater cost on the public purse if the system does not work properly.

Q866 Dr Taylor: I have a series of questions about personal assistants. Remembering that personal assistants might be, as it were, employed by banks of PAs, remembering they might be just privately engaged people, should the new Vetting and Barring system apply?

Councillor Sir Jeremy Beecham: I suppose you could regard it as an aspect of safeguarding in some respects, could you not? Obviously we do take that seriously. Without getting too close to Mr Cameron’s views about health and safety and regulation and that kind of thing, one wants to be balanced about this. The important thing is that councils will ensure that there is adequate training available for people and an expectation that those who are assisting will have undertaken some training and on a continuing basis, and that this is a factor that people will be encouraged to take into account when they are making their choices. How formal it has to be, I am not really qualified to say. Certainly on the training side there needs to be some investment in ensuring that people have the necessary skills.

Ms Owen: There are risks and balances here. If you regulate the PAs through the Vetting and Barring system, then you may have some risk diminished but you will also lose flexibility. You may have a range of people at the moment who would want to help you with your PAs, some of your neighbours and so on, and if you have to go through a whole system that might be expensive and certainly would be administratively burdensome. Would people say, “I don’t really want to be bothered to do that”? You could lose on the flexibility but at the same time you might be able to safeguard against risks in a certain way. We are still looking at it in terms of a position. We do not know how many self-funders there are who are living at home, but let us just say that half the people who need social care services are self-funders who do not get any of the regulation that potentially we are talking about, then it is really important that safeguarding systems are built into the normal way in which we do our business. Things around how we make sure things are legal, trading standards, and all those ways in which you can diminish risk to us in the community are the things that we need to be looking at. There is an overarching general way in which we need to make sure that there is safety in services, and then there is something about do you get into Vetting and Barring, which has checks and balances.

Councillor Sir Jeremy Beecham: There is also a role presumably for general practice here. Obviously there should be contact. Given the fact that people are clearly in need of support anyway, there ought to be contact with their GP. One would hope that there would be some attention paid within the practice by doctors or other staff to keep an eye on how people are faring under the system. Without getting that too formalised, there needs to be liaison obviously with those with responsibility for care, whether it is a personal assistant or the GP practice, or, I guess, hospitals if they are involved as well. They would not just be standing on their own as personal assistants; there would be other people around with an interest who in that way able to keep an eye on the situation.

Q867 Dr Taylor: That is almost an ideal world, is it not? We all know GPs are rather pulling back from watching people in their homes.

Councillor Sir Jeremy Beecham: Or visiting people in their homes or doing anything very much, it seems to me sometimes—but that is perhaps another story.

Ms Owen: Of course local authorities still have a duty to review people who are having care and support, so we will continue to have that.

Q868 Dr Taylor: Even self-funders.

Ms Owen: Not self-funders. People who are paying through their personal budgets to have a PA, we have a duty of reviewing.

Q869 Dr Taylor: Would it be preferable for future people hiring personal assistants themselves to be able to call on the banks of PAs that councils hold? Because those would be approved people, is that what we should aim for really, that everybody should have access to a bank of vetted people?

Councillor Sir Jeremy Beecham: They should have access to it but not necessarily be required to use it it is probably the way to put it.

Q870 Dr Taylor: Access but choice.

Councillor Sir Jeremy Beecham: Yes.

Ms Owen: Yes.

Q871 Dr Taylor: The very last question you have partly answered. Are there any restrictions that should be put on what people can use their direct payments for?

Ms Owen: They should not do anything illegal.

Q872 Dr Taylor: That we have heard before. That is the only restriction we have had so far.

Ms Owen: The most important thing is that it meets the care and support needs.

Q873 Dr Taylor: That is right. They have to be able to choose, do they not?

Councillor Sir Jeremy Beecham: Yes.

Dr Taylor: So only that they should not do something illegal.

Ms Owen: Yes.

Dr Taylor: Thank you.

Charlotte Atkins: Thank you very much for coming along today and helping us with our inquiry. It has been a very useful session. Thank you.
Thursday 7 January 2010

Members present
Mr Kevin Barron, in the Chair
Charlotte Atkins
Mr Peter Bone
Sandra Gidley

Ms Hobbs: I am Hazel Hobbs, Joint Head of the Disability and Carers’ Benefits Division, Department for Work and Pensions.

Mr Behan: I am David Behan, Director General for Social Care in the Department of Health.

Andy Burnham: Thank you very much. I am Andy Burnham, Secretary of State for Health.

Q874 Chairman: Secretary of State, welcome back to the Health Committee. Perhaps I may ask you and your colleagues formally to introduce yourselves.

Andy Burnham: Thank you very much. I am Andy Burnham, Secretary of State for Health.

Q875 Chairman: This is the seventh and last evidence session of the Committee’s inquiry into social care. Secretary of State, it has been argued that the current limitations of social care services place an unfair burden on many informal carers. What should be the balance between care provided by the state and that provided by family, friends and neighbours?

Andy Burnham: That is a massive question. Perhaps I may begin with an acknowledgement that I do not believe the Green Paper talked enough about carers and how this reform might benefit them and remove the burden from them. The experience today of carers up and down the country is that there is good support out there, albeit variable, but often they face a real battle to get that help particularly when they look after those with severe needs. Life is a battle. Looking back, we were probably very good on the technical nature of the arguments for reform but we need to explain better as we move towards the White Paper how this reform will benefit carers by providing more control, the ability to call down services when they are needed and the ability to invest in a better trained and more motivated workforce. I believe that all of those are really important issues that need to be elevated in our consideration as we move towards the White Paper.

As to the balance, we must acknowledge that whatever we do in any reform of social care in this country must be based on the bedrock of family, friends, communities and neighbours. I do not think that as a society we can function without that bedrock of informal love, care and support that helps people through the later stages of their lives or adults with disabilities in the earlier part of their lives. What is the right balance? That is really what we are trying to discover in our consideration of all the options. We issued the carers’ strategy two years ago. The balance and fairness as it affects carers must be an important part of our consideration as we get to the final analysis. There must be a contribution by the individual giving time and energy to support loved ones. We know that is what they want to do, but the state needs to do more to make life tolerable for them so they can care and raise their own children or go to work and I believe that today we are not doing enough in that regard.

Q876 Chairman: Some commentators have said that the more care the state provides the less incentive there is for family and friends to care. What is your view? You are telling us this morning that where there is a greater role for individuals because of the severity of the needs under those circumstances the state needs to care more, but does it disincentivise families from helping?

Andy Burnham: I do not see it that way. We have to make life tolerable for them; we have to give those carers a certain quality of life through this reform. This is not about replacement and if one looks at the demographics and the public finances in the long term it just cannot be. It would be wrong from a policy as well as a moral point of view to suggest that the country cannot make that vast contribution through informal care and support. Why should the state move into that territory? That is the proper preserve of families, relatives, communities and neighbours. But one must make it tolerable for those who want to provide that informal support to do it and give them support when they need it so they can have lives themselves. In particular I am very struck by some of the stories I hear about young carers and the life chances they lose through the support they give. What more can we do to let carers do what they want to do as loving family members but at the same time not stifle their own opportunities in life? When the White Paper emerges it needs to be more expansive on this point.

Q877 Chairman: Referring to the Green Paper, our evidence shows great variability in the level of social care support between different areas. Sometimes in neighbouring local authorities there is a great difference. Are you not bound to choose the option in the Green Paper of a fully national system on the basis it is the only way to address that?

Andy Burnham: Not necessarily because all of the options we have put forward are consistent with a national care service. Obviously, the political judgment is about how big one builds that national care service. Under the partnership, the insurance and comprehensive option, one can have national assessment and entitlement. Obviously, the question...
is: entitlement to what? That takes one into the question of how big one makes the offer. I agree with you. In recent times there has been a lot of fashionable talk about localism and giving people the ability to run things at local level. I believe that often the public do not want a postcode lottery certainly for healthcare but also social care; they want clarity about what they can expect and they want it to be fair across all areas. I believe that the case for national entitlement and assessment is very strong. I am very encouraged by the stance of the LGA. When Sir Jeremy Beecham was before you he did not argue against that. I believe that in that context he had an issue about the word “service”, but he spoke of a national care guarantee. I welcome the fact that local government also embraces that. As you rightly say, because of pressure on finances councils have moved towards the substantial or critical end of eligibility criteria in terms of where support is provided. I was told by Mr Behan a few days ago that only one council in the country provided support in all care categories. As things get harder people retreat to the critical and substantial end and that creates real unfairness and variation across the country.

Q878 Chairman: It was reported in last month’s Health Service Journal that the government intended to overcome poor co-ordination of health and social care services by placing social care effectively under the control of primary care trusts. Is there any truth in that?

Andy Burnham: I believe that story was overwritten. I do not know the source of information for that story. Obviously, the Green Paper talks of different delivery structures: a national system, a part-national and part-local system or a local system. As any green or white paper process proceeds people test ideas and models, but to say there has been a policy decision or decision in principle on a takeover is quite wrong. Members of the Committee will recall when I sat on their side of the table. I am an integrationist on health and social care. Chairman, your esteemed predecessor convinced me of that. Dr Naysmith will remember well the inquiry into delayed discharge. We spoke at length about these issues. He convinced me that we needed a more integrated system of health and social care in this country, so I was won over then. That does not mean a takeover by health or local government. In the coming period in the National Health Service I would feel very comfortable about PCTs increasingly merging functions with adult services. We already know that there are some shared chief executives. Knowsley is one and there are other examples round the country one can move towards integration without it being a takeover and I believe that in that regard the HSJ has overwritten it.

Q879 Mr Bone: Is there a danger in executives of whatever political colour wanting to get their policies enacted and removing powers from local government because over a period of time local government tends to go to the opposition parties? Therefore, if you move it to the primary care trusts you move the policy into the power of the executive and away from local authorities. That seems to be an attraction for every executive, but do you not see the danger that therefore everything becomes controlled nationally rather than local authorities and politicians making decisions?

Andy Burnham: I understand the point you make. I think you imply that that may have formed some part of our thinking, but I can assure you it was not. There is good reason for the health service being organised in the way it is so you do not have fluctuation. When you talk about services that are critical—often they are sophisticated in nature or are specialist tertiary services—I do not think that for any community they can be subject to the ebbs and flows of local opinion; they need to be on more solid ground. When it comes to social care there can be greater local expression, variation and a mixed economy and that is the way it has developed in this country. In times past when it has been difficult financially one of two things occurs: either health and social care pull apart and become very precious about the boundary or they can say that they are all in this together. We have a common goal here and we need to pool our resources. Recently, in the operating framework we said we did not want PCTs to be “policing the boundary”. I am very clear about that. There is more evidence than when I was won over to this particular cause. You can help social care work together more closely as partners without it always being seen in the context of a takeover of one side by the other.

Q880 Dr Naysmith: We have heard from a good number of witnesses and have seen evidence to indicate that there is a significant unmet need for social care services. This is also related to the earlier point that there are much better services in some parts of the country than in others, but the question is that apparently the Department of Health does not have any idea of exactly how much unmet need there is. Why is this not properly monitored, and what will you do to find out more about it?

Andy Burnham: That is a very important question. We do have an idea. I think the up-to-date figure is that there are about 300,000 people with substantial needs.

Q881 Dr Naysmith: That is a bit of an estimate, is it not?

Andy Burnham: It is, but one must also acknowledge that it is a product of the system that I described. There is responsibility at local level for eligibility criteria and the levels of support provided. That fluctuates according to political decisions. It can then affect levels of unmet need in any particular community. I take on board the point you make, but it is a feature of the current system that levels of unmet need can fluctuate according to local decision-making.

Q882 Dr Naysmith: But we hear there are some authorities that do not even keep a record of people who have unmet needs; they do a very quick assessment and just tell people that they cannot do anything for them.

Andy Burnham: I do not want to second-guess what the Committee will say about that, but I do not find that acceptable. There is a statutory requirement to
Andy Burnham: wrong? Have you made any assessment of where it is going? We have had a good deal of evidence about poor quality residential care and the thrust of what we say in the Green Paper is that operators are negligent or uncaring but we have the opportunities that exist in the National Health Service. For me, it is not necessarily the case that operators are negligent or uncaring but we have a system that is struggling to cope and when that happens standards may not always be what we want them to be. I hope we are building a consensus that there needs to be a more national approach to these important matters in terms of both assessment and entitlement. It follows that there is a standard approach to how we deal with it based on the need we identify through that process.

Q883 Dr Naysmith: But you recognise that it must be recorded properly so it can be assessed?

Andy Burnham: Yes. I give a personal view here. This is the responsibility of councils and obviously I am not here to dictate to them how they do their job, but the thrust of what we say in the Green Paper is that there needs to be a more national approach to these matters in terms of both assessment and entitlement. It follows that there is a standard approach to how we deal with it based on the need we identify through that process.

Q884 Sandra Gidley: We have had a good deal of evidence about poor quality residential care and Gerry Robinson’s recent television series seems to confirm that. I am not here to dictate to them how they do their job, but the thrust of what we say in the Green Paper is that there needs to be a more national approach to these important matters in terms of both assessment and entitlement. It follows that there is a standard approach to how we deal with it based on the need we identify through that process.

Q885 Sandra Gidley: It is probably fair to acknowledge that there has been some improvement in standards but it has been slower than a lot of us would have liked. Obviously, if some providers can provide a service one wonders why others with similar money cannot. The Care Quality Commission has taken over from CSCI. How will that new system measure quality rather than do just a tick-box exercise that some of the previous systems have been?

Andy Burnham: To give some figures, 77% were good or excellent in 2009 and that was an increase from 69%. I do not want to sit here and appear as though I have a downer on those providers. I do not.

Q886 Sandra Gidley: I understand there has been an improvement.

Andy Burnham: That is a fair point. It means that about one quarter is not achieving those levels. Rightly, you ask why they are not. They should be. To go on to the new system of registration, obviously the idea is that it takes a more in-depth look at care quality standards across any institution. We are bringing forward the regulations to set up the details of that process, but the aim here is to increase the powers of the CQC to tackle those areas where there are serious failings. To go back to my constituency experience and the old CSCI system, I was disappointed by the approach which was almost a slap on the wrist; there was a sense that the powers were not as tough as they might be. When we talk about the care of elderly or vulnerable people we need pretty tough powers to intervene and sort things out and obviously that is part of what we are trying to do.

Q887 Sandra Gidley: The former chair of the Care Quality Commission, Baroness Young, told us that there was a clear “gradient” in quality between for-profit and non-profit providers. Do you accept that social care providers could be putting profit ahead of quality? Is there any way that the state can achieve a reasonable balance between the two?

Andy Burnham: I cannot speak for them all but I hope not. I have no ideological objection to the mixed market in social care that we have. There are excellent private, voluntary or charitable providers; there are excellent in-house or council providers. I do not believe that their status should necessarily determine the quality of service they provide. If there are examples where people clearly put profits and margins before care or the basic job they are paid to do that is fundamentally unacceptable. Clearly, the CQC is looking closely at that issue and were it to take action against any organisations where that could be proven I would back it wholeheartedly.

keep people safe. Authorities need to be on top of that. I would have thought that not just in practice but morally it is right to ensure that an overview is taken of levels of unmet need in the community because it can affect all public services, not just council services but also the NHS. We see levels of unmet need rising potentially if we do not reform the current system. The estimate is that the number of people with unmet needs will go up to 400,000. I agree with you. A huge driver of this reform is that we do not leave that level of vulnerability out in the community and then do not have an adequate way to address it.

Q883 Dr Naysmith: But you recognise that it must be recorded properly so it can be assessed?

Andy Burnham: Yes. I give a personal view here. This is the responsibility of councils and obviously I am not here to dictate to them how they do their job, but the thrust of what we say in the Green Paper is that there needs to be a more national approach to these important matters in terms of both assessment and entitlement. It follows that there is a standard approach to how we deal with it based on the need we identify through that process.

Q884 Sandra Gidley: We have had a good deal of evidence about poor quality residential care and Gerry Robinson’s recent television series seems to confirm that, although obviously that is only a snapshot. Why is there still so much poor residential care? Are under-funding or staffing issues to blame? Have you made any assessment of where it is going wrong?

Andy Burnham: Standards vary across the system. As an MP I can recall some appalling cases of failure in care homes in my constituency. On the other hand, the recent CQC survey found that on the whole the picture was pretty good and the vast majority of care homes and institutions provided a good standard of care. I am sure the Committee has those figures. The picture did not show deterioration but an improvement. I agree there are some institutions where there are appalling failures and unacceptable standards. Some years ago the government introduced the Care Standards Act which provided a framework that did not exist before, but these are issues about which I worry a lot. You may have heard me say before that through my grandparents I had personal experience of the care home system. It was not acceptable. I worry about the investment in the social care workforce. I believe Sir Jeremy Beecham in talking about domiciliary carers told you that in many cases people were paid at or close to the national minimum wage. Clearly, they do not have the opportunities that exist in the National Health Service. For me, it is not necessarily the case that operators are negligent or uncaring but we have a system that is struggling to cope and when that happens standards may not always be what we want them to be. I hope we are building a consensus between the parties that we must reform the social care system and find a way both to spend better the money we put in to support vulnerable people and, if we can, bring in extra money to raise the standards in our care service. The poor standards to which you refer are I believe more a product of stretching resources ever-more thinly with local authorities having to be tougher with providers about the fees they can provide. We have to reverse the situation and improve the overall offer.

Q885 Sandra Gidley: It is probably fair to acknowledge that there has been some improvement in standards but it has been slower than a lot of us would have liked. Obviously, if some providers can provide a service one wonders why others with similar money cannot. The Care Quality Commission has taken over from CSCI. How will that new system measure quality rather than do just a tick-box exercise that some of the previous systems have been?

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Q888 Dr Taylor: I want to ask about the Green Paper consultation. When and how will you be publishing the outcome? Are you allowed to tell us anything about the outcome of the consultation now?

Mr Behan: I believe it would be inappropriate to disclose the detail of the outcome of the consultation. The contract for the analysis of the findings is with Ipsos MORI and we expect a report from them soon. Our expectation is that we will publish the outcome of the consultation later this year.

Q889 Dr Taylor: You say “soon” and “later this year”.

Mr Behan: We have contracted with Ipsos MORI. We had over 28,000 responses and ran 37 stakeholder events across the country, so we have a mass of feedback from a wide range of organisations that we are analysing. We have asked Ipsos MORI to undertake some of that high-level analysis for us and are receiving weekly reports from them on the progress of the work, but later this month we expect to get the final report from them. We will then use that to inform the work we are undertaking in producing the White Paper. We would expect to produce the outcome of the consultation in accordance with Cabinet Office guidelines on responding to consultation later this year. That is the process we have been pursuing in the consultation and what we have had back. It has been a massive response. Responses have been sent in by key organisations. Over 24,000 that have come through are in the form of electronic consultation and massive information has been generated by our consultation events and the road shows held throughout the summer and earlier part of the autumn.1

Q890 Dr Taylor: Were you surprised by the extent of the responses? Looking at the consultation questions I must say I regarded them as rather uninspired but somehow they seem to have inspired interest.

Mr Behan: I believe there is huge interest in the work and consultation. This is an issue that touches the lives of many people. It became clear from the consultation that the case for change, which we set out in May 2008, has largely been accepted. I am thinking of the people who have given evidence to the Select Committee in this inquiry. Many people have argued that the case for change is accepted given the growing number of older people because of the aging of our society and the increasing number of younger people with disabilities who will require care. The case for reforming the system and developing it has largely been accepted. When people were drawn into the consultation and responded to the events I think they began to engage with some of the issues and key dilemmas. The very first key dilemma was to do with a national system and people began to engage with that and express a view. We have been delighted with the response. Like all these things, we wish we could have penetrated more organisations and people but the response has been fantastic. In terms of electronic communication I believe it has been the greatest response that government has ever had to any of its consultation. The quality of what we have received from key stakeholders and organisations has also been very high.

Q891 Dr Taylor: Therefore, our impression that the big care debates had a rather low profile is quite wrong.

Mr Behan: To be truthful, I think it is. There has been a fantastic engagement. When we have conducted regional events road shows have been held on high streets. I have been on a number of them, as has the Secretary of State. Thousands of people in Newcastle came down the Haymarket and contributed to the show. They stopped, filled in questionnaires, spoke to people on the stall and engaged in the debate. We have used very different techniques from those traditionally used by government to engage a broader range of people and we are very pleased with the response, but penetrating a wider range of groups beyond the normal stakeholders and people who were using services is one of the key challenges.

Andy Burnham: I did go along to one of the sessions described by Mr Behan. The people we employed to do this had a wonderful team who were very passionate about the issues. They were just off the street meeting and talking to people, capturing some incredible stories and reflections from members of the public who were out shopping or on their lunch hour. This happened up and down the country. It was well beneath the radar of this place, but some fantastic work was done. The extent to which they became inspired and enthused by what they were doing was wonderful. They captured an enormous amount of stuff just off the street.

Q892 Dr Taylor: So, the outlook for translating these splendid words into action is quite good?

Andy Burnham: When I took on the job I made this my top priority. I believed that the reform of social care in this country was long overdue and we could not flinch from it any longer. I made it my mission to get the Green Paper published. Bear in mind that these are complicated and difficult matters. As we all know, there are good reasons why politicians do not want to touch them and probably in the past the issue has been “it’s all too difficult”. I do not believe we can carry on like that. When I was Chief Secretary to the Treasury I kicked off the process in the spending review with the department looking at the reform of care and benefits. I wanted the Green Paper to be published and it was. I was very pleased by the level of ambition in the Green Paper, although I acknowledged that there were weaknesses in it. I referred to one of those in answer to the Chairman. I want to create unstoppable momentum for a bill in the next parliament which fundamentally reforms the funding of social care in this country.

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1 The Department of Health has subsequently clarified that the figure quoted should be 16,000.
Q893 Dr Taylor: We were given the quotation “unstopable momentum” and from what you have said you appear to have achieved it. It is encouraging.

Andy Burnham: I am not sure yet. Bear in mind that we are going through the replies. I have indicated that I want to publish the White Paper this side of a general election. I believe that social care should feature prominently in the top issues of the general election. I would encourage the Wyre Forest Independent Party to include it in its manifesto at the coming general election. I am not sure it has yet had its conference and decided on the matter. I want to make it one of the top issues so the country can debate these matters and there can be a clear expectation outside of that general election that the next parliament will legislate on the reform of social care. As to the White Paper, it may be that opinions move on and people will take a different view, but the departmental team led by Mr Behan is a wonderful body of committed people. They have done fantastic work on the Green Paper to bring us to this point. If the White Paper can follow the very high standard of the Green Paper it will provide the basis for reform of any kind that any party chooses to make. That is what I am trying to achieve.

Q894 Dr Taylor: We can expect the White Paper and the responses before an election, so your staff must work pretty quickly. That is hopeful and encouraging.

Andy Burnham: This issue is like Lords reform; it is bedevilled by momentum or lack of it. I do not know whether colleagues want to come on to talk about the Personal Care at Home Bill, but very much at the heart of that measure is momentum. We have talked about it and decided to get on and do it. That again is a key part of the momentum we are trying to build. We are now going to take it forward.

Q895 Charlotte Atkins: You mentioned weaknesses in the Green Paper. One of them can be identified as lack of focus on mental health issues. One of the problems in mental health is that it fluctuates and therefore it is difficult to provide social care. Having said that, if mental health problems are picked up early there can be a huge saving to the state and it can give people who have mental health problems a real chance in future to overcome them. Where do you believe mental health fits into the social care agenda?

Andy Burnham: It is critically linked, is it not? I would encourage you to look at the Green Paper alongside the New Horizons document that came out last year. One of the things about government is that it takes an issue and deals with it in a very focused way and can often miss some of the broader picture. But inevitably the media representation of these issues talks about the elderly having to sell their homes and other things and the costs of growing old and does not, frustratingly, give due prominence to adults with disabilities who are an equal part of the Green Paper. Obviously, those challenges can be mental health, physical disabilities or sensory impairment. There is a slight frustration there. It is not so much a matter of deficiency in the Green Paper as some of the debate it inspires focuses almost exclusively on the costs and care needs of growing old and not enough on supporting adults with disabilities throughout their lives.

Q896 Charlotte Atkins: It is not just adults. There should be intervention almost at school level where mental health problems start to emerge. In my local area we have an excellent drop-in centre called Room 21 within Leek High School where youngsters can come and discuss their issues. There does not appear to be a general focus on how to pick up these issues early.

Andy Burnham: I would debate that. We have the Improving Access to Psychological Therapies programme which in some areas has a particular focus on young people. There are such services for young people, but the criticism you make is a fair one.

Q897 Charlotte Atkins: There is some excellent work going on but it is not sufficiently general.

Andy Burnham: Is it sufficiently connected to other things we are doing? I think you are right. This was an area that had not been properly prioritised but through the work that has been done under the Improving Access to Psychological Therapies programme we are beginning to put in place preventative mental health services around the country. There was fairly good progress on it last year and some PCTs focus particularly on services for young people. An excellent piece of work is the Young Minds manifesto. I acknowledge the need to connect all of these different things, but the Green Paper is not condition-specific; it talks about people with all social and personal care needs.

Q898 Chairman: On the need to reach a consensus, clearly this morning you have made a pitch to get consensus with the Wyre Forest Independent Party. Are you likely to be holding any discussion with other political parties about the content of the White Paper to try to reach a consensus on the issue of funding of social care?

Andy Burnham: I would welcome any such discussions. I said when I began that these issues are so fundamental and touch so many lives that you cannot carry out reform in a heated, polarised way. There has to be a settled consensus in the country that whatever option is chosen is the right one. Inevitably, we should properly have discussions with the other parties to see how much we can agree and what is the difference of opinion. Can one reform so far and then have different views about the rest? When I say I want to make it an election issue that is not overtly to politicise it in an unhelpful way, but it is right that the country hears the debate about social care and that the election lifts it up and recognises that the country is growing older and this must be a big priority for any incoming government. I believe that to be a healthy part of the democratic process and the parties should have their arguments
at that level, but I would welcome any approach beneath that to discuss things on a more consensual basis.

Q899 Sandra Gidley: I want to return to “unstopable momentum”. You appear to believe that the Personal Care at Home Bill was part of that, but other witnesses before this Committee have regarded it as more of a diversion hastily cobbled together which cuts right across the Green Paper. Would it not have been better to wait until all the responses were in and you had something that was complete and coherent?

Andy Burnham: I hear what you say, but let me give you my version of it in which I believe passionately. Social care does not stand still because we have a green paper. Putting People First was an attempt to put some oomph behind direct payments, personal budgets and the personalisation of services. That is a very good piece of work. We have the carer strategy and dementia strategy. Phil Hope has done wonderful work on all of these fronts. As Charlotte Atkins said a moment ago, these are complementary; they are building the national care service reform as outlined in the Green Paper. Putting People First is entirely consistent with that, as are the carer and dementia strategies. In that category I would place the Personal Care at Home Bill for two clear reasons. You say it cuts across the Green Paper. I fundamentally reject that. First, a national care service, with which I began, has to end the lottery and variation and give national entitlement. Therefore, this Bill deals with the most vulnerable people who at the moment face a lottery. For some their domiciliary care is fully funded; for others it is part-funded; and for others it is free because their council makes such provision. The most vulnerable people in our society who have probably already paid out of their own pockets significant amounts for the cost of their own care currently face a lottery, so this Bill begins the process of making the system fairer now for that group and makes it a national approach for that group. That is fundamentally one way in which the Bill lays the foundations for a national care service. The second very important way in which it does that is by the linkage between the offer of domiciliary care with re-ablement and the emphasis on building preventative services in every local authority area that keep people active and independent for as long as possible. In that way this Bill builds the vision of the Green Paper. It is consistent with all of the options in the Green Paper because re-ablement is part of all the options. By pump-priming the development of re-ablement services across the country we are bringing forward the vision in the Bill. When we discussed these issues as a cabinet in Building Britain’s Future and published the Green Paper shortly afterwards we lifted the whole debate in government about social care and created excitement about it. There was real willingness to move and put in place some of the fundamentals consistent with any of the options in the Green Paper.

Q900 Sandra Gidley: You are saying that this was a Cabinet decision. I was going to ask whether this was something that you pushed forward or the Prime Minister wanted an eye-catching initiative prior to the election.

Andy Burnham: The Cabinet had a number of discussions around the time we published Building Britain’s Future about policy and policy development basically to have the right answers to the big challenges faced by the country. Whatever distractions we may have from time to time that is the job we are elected to do and what we have to focus upon. I think every member of the Cabinet believed social care to be an area that had not been properly reformed and was one of great unfairness where those who had the worst hand of cards in life currently had the worst deal; they could see all of their savings wiped out, and we, the Labour Party, should now do something about it. Those discussions lifted the whole focus of everybody on social care. People say we have been in for so long and ask: why now? One can do only so much. We have had a pretty important job to do with the NHS; we have put a lot of focus, energy and attention into reform of the health service. I believe we can say with some justification that it has improved significantly as a result. We did say that we should reform social care but the Royal Commission did not help build the consensus required for this reform. I believe that essentially it knocked it off the agenda because it could not itself find a consensus on that reform. I want to answer you as openly and honestly as I can. David Lipsey’s characterisation of the Bill as an Exocet is 100% wrong. In all of the guises of the national care service this Bill lays the foundations; it is a stepping stone or bridge to it. To say that it has been unilaterally chucked in is wrong.

Q901 Sandra Gidley: There appears to have been a lack of thinking of the consequences of this. Quite a lot of people have raised concerns that families will try to keep people who need residential care out of such care because they get a better deal if mum or dad is looked after at home. There have also been concerns that local authorities will change their criteria accordingly. How do you respond to those accusations?

Andy Burnham: I think they are fair points and that is why Mr Behan and his team have said that the policy will have to be reviewed in 18 months, but we are not cutting against the grain of what is going on in local government. Let me give you one example. As I understand it, the Isle of Wight made a political commitment to deliver free care in the home for people over 80. It was an aged-based and not a needs-based commitment. They did it by funding re-ablement services in a much more serious way themselves. They fully funded the political commitment, and with a bit extra I am told, through the savings they made on less use of care homes, so by more proactively keeping people well and preventing, for example at danger points after operations, falls, bereavement or something, they changed the way they worked. Lots of local authorities are looking at how they can make savings by reducing their
dependence on residential care settings. I would argue that we are going with the grain. You referred to people being given certain incentives. This cannot be about putting people inappropriately in any setting. That would be wrong. I do not think it is a bad thing at all to have a system geared towards prevention that pulls people back to the home, keeping them healthy and safe. David Lipsey refers to the “pernicious view of ministers” about people being in their homes. We hear that that is what people want. I think it is morally right to focus all our efforts on helping people live as full and independent a life as possible, recognising that there will always be some for whom residential or nursing care is the correct setting. I feel very strongly on this point. I do not believe that we are cutting across the direction of travel in local government. The guide to use of resources that we published just before Christmas shows real variation in terms of spend by local authority on residential care; it goes from some 30% in some local authorities to 70% in others. Local authorities are at different stages of the journey but the direction is all towards more support in the home, not more use of residential care. I accept that this Bill does not solve all the problems of the world. It is not the whole answer, but it is a genuine effort.

Q903 Dr Taylor: I am very relieved to hear you say there will always be some people for whom residential care is the best. I think particularly of those elderly who are entirely alone with no family at all. They may not have much in the way of physical disability but they need company which they can get in residential care. If they are kept at home they will lose out on that. I am also worried about the people who are very severely disabled. Surely, it will be more expensive to keep them at home than to have them in some form of residential care. Therefore, if more people qualify for free personal care than you bargain for and some of that care becomes extremely expensive where will the money come from? Will government funding increase or will it come from local authorities and thus an increase in council tax?

Andy Burnham: I agree that there will always be a group of people for whom residential care is the right place, but we must not begin with the assumption that we decide it is the right place for them; they and their families decide that it is the best and safest place for them for company or any other reasons. A system based on personalisation must have that at its heart. There will always be people who make that choice.

Q904 Dr Taylor: But it is free for them at home but not if they go into residential care.

Andy Burnham: That is why I say the bill is a partial reform. Obviously, it tries to build the preventative service that we want to see because we believe it is right to work harder at the front end when people begin to require the care system. As I have acknowledged today, this bill is not the final solution and in future it should work across care settings and choices. It can have a strong preventative emphasis but it should respect people’s choices and work across that care spectrum.

Q905 Dr Taylor: You have mentioned Sir Jeremy Beecham. He told us about the New Burdens Doctrine where I am told the government promises to fund fully the cost of new policies imposed on councils by Whitehall. Is that right?

Andy Burnham: The “Use of Resources” document identified £250 million efficiency savings that we believe are there to be made. That was confirmed in the pre-Budget report.
Q906 Dr Taylor: That is £250 million for each council?

Andy Burnham: No, overall. Those savings are there to be made addressing the variation that I just described in answer to Sandra Gidley a moment ago. We believe there are significant savings to be made in building that more preventative service. It is not pie in the sky; the Isle of Wight and others are doing it. The Department of Communities and Local Government does not consider this to be a new burden; it is part-funding and brings a lot of new money to the table for local government to build those services and help them achieve those savings. We see this as a partnership, not the dumping of a new burden. It very much nationalises the example of the Isle of Wight.

Q907 Dr Naysmith: I believe it is pretty well agreed that to fund free personal care the Department of Health will have to find £420 million a year. You said in an interview with The Times that of that £60 million would be re-prioritised from lower priority health research and development and £50 million in savings from public health campaigns. Can you explain what you will be cutting in those two instances and tell us where the rest is to come from?

Andy Burnham: The bill does cost £420 million in its first full year. It will come in from October of this year, so it will be a half-year cost in the last six months of the current spending period. The full year cost is £670 million of which the £420 million is a part. We are looking at a half-year cost of £210 million. I am reprioritising central budgets to pay for it.

Q908 Dr Naysmith: What is low priority health research and development, for instance? The Times suggested that you might cut research into cancer, dementia and so on.

Andy Burnham: I vehemently and immediately made it clear that that was not the case. We are not doing that. On the day I spoke to The Times I said that we would not cut front line research into cancer or other high-priority conditions. What we are doing is consolidating all spending of Department of Health research inside the ring fence that is in place. As part of that process we can release savings from the administration of the research budget. I do not mind being held to account for what I am actually doing but not for what I am not doing. It is hard to take forward a reform of social care when an accusation about cutting research into cancer is the kind of allegation being thrown about.

Q909 Dr Naysmith: But you still have to give me an example of what a lower priority health research and development topic is. If it is not cancer what is it?

Andy Burnham: What I can give you are the indicative areas from where I am taking this funding. I shall come on to research in a moment. The first is spend on communications. We are taking considerable amounts of funding from that area and from consultancy. We were doing it anyway because we had pressure from swine flu. We are reconsolidating the DH research budget inside, not just the stuff that is in the research ring fence. As a result of that we can release £60 million of savings. I do not today have a precise list of the implications of doing that, but I undertake to give you more information as I have it to spell out the practical implications of doing it, but I can say that it will not affect our commitments to important research into the big killers, motor neurone diseases and all those areas in which we have invested heavily over recent years.

Q910 Dr Naysmith: The other area is public health campaigns. You will remember from your time as a member of the Select Committee on Health that we prepared reports regularly that not enough was being spent on public health. People were always coming forward to say more needed to be spent on it. A cut of £50 million is quite considerable. I believe that when you were a member of the Committee we conducted research into sexual health which gave rise to a lot of public health messages. We needed to boost it, not cut it back.

Andy Burnham: Yes.

Q911 Dr Naysmith: So, what can you cut in public health campaigns?

Andy Burnham: These are not easy choices. In all of these decisions there is a trade-off. Some might like to think that there is endless waste in the Department of Health. That is not the case; the department is a tight ship. We will have to make some difficult decisions. The judgment I make is: is it right to get more support to the most vulnerable people in our society who already fund their care to a significant degree out of their own pockets? Is it right to start now to build a more preventative social care system? In considering that, is it a higher priority than the other things we are currently doing? My judgment is that it is. It is like the research budget. It will not necessarily have a huge impact on the front line. We are looking at how to get a different deal for how we procure advertising and communication space from the media. That can release some savings. We are taking a very tough approach to the use of management consultancy. We have been criticised for that by this Committee in the past. We are really taking the toughest possible approach to backroom spending and protecting the front line, but that applies to the research budget too.

Q912 Dr Naysmith: I move on to the future overall funding envelope, to use technical jargon; that is, how much from all sources is spent on social care. That is crucial and yet the government has been silent on the overall amount of money that is to be spent on social care. How can you talk about reforming social care until you have resolved the overall funding envelope?

Andy Burnham: Obviously, those are decisions for the Treasury and the Chancellor. Spending on social care through local government is obviously a decision for the Chancellor when the final spending review is completed. Obviously, we must make assumptions about trends and how they might
develop. The Committee has figures to show the amount spent at the moment which I believe is in the region of £16 billion. That comes from a range of sources. Some of it is raised locally; some of it is in the form of grant that my department makes available to local government; and some comes from the DCLG revenue support grant. Obviously, we cannot prejudge spending reviews in future. Ms Hobbs can give you more figures. We have given figures for the actual spend on Attendance Allowance today which obviously is relevant to this issue.

Q913 Dr Naysmith: You are confident that you know exactly how much it will cost but you have no idea from where the money will come in future. From my point of view we could get rid of a nuclear submarine or couple of nuclear missiles and spend all this tomorrow, but that is not for your department. Presumably, you will be fighting other departments when the spending round begins to try to get money for this. I agree that it is something we should be doing for older and vulnerable people. Obviously, you are on a campaign, and good luck to you.

Andy Burnham: I am on something of a mission with this reform. I agree that we need to do more. I come back to the critics of the bill. On what basis should we not be giving more support to people who have been dealt the worst hand of cards that life can offer? I do not have any time for that criticism. I am making some tough decisions and wherever I can moving my department out of the backroom side of what we do: communications procurement and administration of the research budget. The whole approach is to protect the front line and be tough where we can move money out of the back room. That is what we are doing. For any of the options we choose under the Green Paper it must be a collective approach is to protect the front line and be tough where we can move money out of the back room. That is what we are doing. For any of the options we choose under the Green Paper it must be a collective approach. It must be a collective approach and indirect discrimination against older people. We made the important commitment last year to make both health and social care subject to the provisions of the Equality Act by 2012. I have thought a lot about how we have got to where we are. In the immediate post-war period people thought differently; they did not get the healthcare they needed and the focus was on rebuilding.

Q915 Dr Naysmith: You will not remember that but I do. Just after the war people did things together in a much more collaborative way than nowadays.

Andy Burnham: I believe this issue comes into focus because of the success of those policies. As life expectancy increases and we become more prosperous and people live longer and more fulfilling lives this issue arises, does it not? It means that we must reconsider reform in this area which I hope can follow similar principles: sharing both the risk and cost of social care across the whole population. That is what we are trying to achieve here.

Q916 Dr Naysmith: Commentators forecast that the state of the public finances makes it inevitable that there will be substantial real-term reductions in public expenditure particularly in social care from 2011. Are they right? If so, you have a real fight on your hands.

Andy Burnham: I cannot prejudge the rest of the spending review. You may be aware that the Prime Minister said social care and its reform would be the top domestic priority for the government in the next parliament. That is an important statement. Obviously, one also has automatic spending as opposed to just departmental spending. Again, if we did not do anything to reform the system it is not necessarily the case that the state would spend less on care and support; one would probably see automatic spending in this area rise which means that overall state expenditure in this area would rise. For instance, if decisions were taken at local government level to provide less support perhaps it would push more people towards the DWP support that is available to try to make ends meet. In any assumption about future spending you come back to the point that the current system is not sustainable. At whatever level the Treasury decides to fund social care through DCLG and my department one comes back to the same point: whatever is available, one should not fund it through the current system.

Q917 Dr Naysmith: Laing & Buisson, for instance, predict that there is bound to be inflation in residential home care costs in the next few years and that will make a big difference to the amount of care even if there are changes.

Andy Burnham: What we have is an inadequate budget being stretched ever more thinly as the population grows older. The unmet need to which you have already referred will increase. The projection is that that need will go up from 300,000 to 400,000 by 2025 or 2026. On today’s figures another 1.7 million more people will need care by that time. Within that people and care homes will face extra cost pressure, so the picture is not a happy one if everybody backs away from reform. I would hope all political parties could commit to a bill in the next parliament because in my view it is absolutely essential.
Q918 Dr Taylor: I want to try to look into the future. What would be the implications for the choice of social care funding if future levels of disability went up? Some experts, Jagger and Matthews, predict that the prevalence and incidence of chronic conditions will rise and mortality rates will fall. That will impose a huge burden. Are you taking that into account?

Mr Behan: Yes, we are. As the Secretary of State said, we have calculated a 1.7 million increase in demand for social care by 2026. That figure is based on evidence and research around increasing numbers of older people, increased life expectancy but also factoring in the fact that whilst the good news is that we live longer lives we are not necessarily living healthier ones. We also factored in the increasing incidence and prevalence of disability within the population, so our 1.7 million calculation of additional demand is based on that evidence. I believe the research you quote has been incorporated into the work that the PSSRU at the London School of Economics has undertaken on our behalf as part of the modelling. Indeed, some of that was published in July of this year so some of the figures that sit behind the modelling are in the public domain.

Q919 Dr Taylor: You take that into account but you do not agree with others who believe that healthy life expectancy will go along with increased life expectancy?

Mr Behan: This is a contested area among academics. A number of witnesses before the Committee have said that some of our figures are underestimates and that comes down to exactly the issue of who is right in the academic world about whether healthy life expectancy is keeping pace with life expectancy. A lot of the figures for our projections are based on ONS statistics and they show that whilst life expectancy is increasing healthy life expectancy at the present is not increasing at the same rate. It is that issue which will drive demand. Whilst there are a good number of examples of sprightly 85 year-olds there are many examples of quite frail 73 year-olds. Therefore, we have to factor in both of those matters. The work done by the LSE is based on what is called a dynamic simulation model to arrive at the notion that these things are changing very quickly. The calculation that we have put in the Green Paper is 1.7 million and we have tried to weigh up that evidence.

Q920 Dr Taylor: That is reassuring. Obviously, you have moved away from constant disability prevalence and incidence which the department has tended to use in the past?

Mr Behan: We have.

Q921 Charlotte Atkins: You ruled out funding social care entirely from taxation as that would mean a significant tax increase for working age people. Should you not ask the public first before you make that assumption? To go back to the point I made earlier about people with mental health difficulties and those with disabilities who are of working age, it is not just an issue of working age people funding those who are elderly and are post-retirement age.

Andy Burnham: We have asked people their views; they guided the debate somewhat in the Green Paper. It has not stopped a good number of people telling us that they thought they should have had that as part of the available funding options. People have told us that and obviously we shall consider it in future, but to make reform happen you must take things forward. The work done by the King’s Fund and others has established the principle of partnership here. The state should provide so much and the individuals should contribute. I believe there is a consensus out there among the political parties of some kind that social care should be a partnership. We are very conscious that it would not be right to ask the working age population to bear all the costs of social care. The test set by Mr Behan and his team was that this reform should be inter-generationally fair, if that make sense; it should be seen to be a fair reform that works across generations. Bear in mind that with the bill since the Green Paper we have increased the tax funding. You can argue about how you set the level of tax as opposed to individual contributions in any system. We believe that the principle that the individual should make a contribution is the right one and it should not be funded just through general taxation. That is a view to be challenged, but experience from other countries shows that is how most fund social care. I believe the Committee heard evidence to that effect.

Q922 Charlotte Atkins: But why does your version of a partnership not include the idea of matched funding which Sir Derek Wanless suggested as a way to encourage people to save for social care costs?

Andy Burnham: Essentially, as a 50-50 partnership?

Q923 Charlotte Atkins: I believe he suggested a state contribution of 66%, so it would be a bigger contribution from the state.

Andy Burnham: Obviously, that is a reasonable point. It is always a question of affordability and we can realistically do without creating a system that would not be sustainable in the long term. The work in which I have been involved in government is as good as I have seen in terms of the quality of thinking behind it and the long-term perspective that officials apply to it. One always wants to do more but one must make it affordable and sustainable. I hear what you say. Maybe a true partnership would be 50-50 or, as you say, an even greater contribution. It is a balancing act and a matter of getting help to those who most need it and giving help to those on the lowest incomes by providing universal entitlement. Those are trade-offs. You could provide less support to the most needy either financially or in terms of their condition and then raise the entitlement for everybody. That would be a political choice but these things must really be considered in the round.
Q924 Charlotte Atkins: A political choice was made in 1948 with the creation of the NHS. Why should it be different for social care?

Andy Burnham: First, it is a different issue. People accept that they have more personal responsibility for living their lives and the things they do in life, for example getting round the house. I believe people accept that they have a greater responsibility for themselves in that way, whereas healthcare is something they cannot do for themselves. A family can do social care for somebody; as an individual you can do it yourself, whereas with healthcare often you cannot do it because you need experts and a different way of providing it. It is a different area and it lends itself more naturally to a voluntary or partnership approach. My vision in terms of the reform very much adopts those principles of the National Health Service that we cannot let some people face the catastrophic costs of care. It may be one in 20 or 25, whatever the figures tell us. It is not right to leave people to face catastrophic costs which any amount of informal care cannot deal with.

Going forward and thinking of affordability, life has moved on fundamentally from that post-war settlement. I would look at my own family and describe it in this way. Whereas my grandparents and lots of others in the North West did not in that era own their own property, my mum and dad do. There has been a big change from then to now in places like the North West. My parents were not university-educated; they did jobs that might be described as ones requiring manual skills. They own their own property outright in a way that their parents never did. That applies to many in my own constituency. Figures show that those over the age of 45 hold 80% of the total net assets of the UK in terms of property. Enormous sums of money are held by the over 65s. It is a changed world for the older population today. Even those who in the past never did own their own homes now do so. Having a discussion with them about how some of that income and wealth can go towards creating a fairer system for everybody is not unreasonable.

Q925 Dr Naysmith: Ms Hobbs, the government has suggested that disability benefits might be reformed by being incorporated into social funding. Can you explain briefly what these benefits are for, who receives them currently and what the rationale might be for integrating the two systems?

Ms Hobbs: The two main benefits paid to older people on account of disability are Attendance Allowance and Disability Living Allowance known as AA and DLA respectively. Both benefits are paid to help with the extra cost of disability. Attendance Allowance is not assessed and paid on the basis of somebody's medical condition or a particular diagnosis but the extra help needed for personal care. The big difference between the two benefits is one of age. You can claim Attendance Allowance once you are 65 but you can get DLA where you are disabled right from childhood. That allowance has an extra element that is paid on the basis of mobility if people need help getting around outside the home.

Q926 Dr Naysmith: How is the eligibility for disability benefits assessed? How does that relate to eligibility assessments for social care, and will that not cause a bit of a problem?

Ms Hobbs: As the Green Paper said, the two systems have a very different history and different bases of assessment. Disability benefits generally go to a much wider group than social care, so in England there are 1.4 million people who receive attendance allowance and a further 625,000 pensioners who receive DLA. The assessment process is largely a paper-based one; it is administered centrally by the Pension, Disability and Carers Service, an agency of the DWP. People generally fill in a claim form by post, phone or online these days. The assessment looks at a whole range of things and picks up mental health issues as well as physical constraints. It will ask people about help they might need to get dressed and so on. There is some commonality there and my colleague Mr Behan may wish to say more about the process for assessing social care. The assessment asks about some of the same things but the outcome is different. Benefits are paid at set amounts and are nationally consistent. The process is much more one of determining whether somebody meets particular criteria in which case that individual receives the same amount of benefit. There is a relationship between benefits and the way local authorities deliver social services. The two organisations work together but the eligibility criteria are different.

Q927 Dr Naysmith: Disability benefits can be described as passport benefits which entitle claimants eligible for other entitlements to make a claim if they have the first benefit. Can you explain how that works and tell us whether people will lose out if the passport benefit is removed?

Ms Hobbs: That is right and it is certainly one of the areas we have picked up in our discussions with voluntary organisations and representatives of disabled people. At the moment Disability Living allowance and Attendance Allowance are used as a passport to a wide range of help, not just within the benefits system. It can range from things like help at leisure centres. The Blue Badge scheme is often mentioned. DLA and AA can be used as a passport to a whole range of help. In this context there are two issues about which we are most concerned: first, the fact that it acts as a condition for the receipt of carer benefits. If somebody has an informal carer, in order to receive carer benefits the person concerned must be caring for somebody who is receiving certain rates of DLA or AA. Second, people can get top-ups on their income-related benefits if they are disabled and receive DLA or AA. The most common example is Pension Credit. People may get a severe disability premium on top of his or her pension Credit. In the Green Paper we have said that if decisions are made on a funding settlement that change the way benefits work at present we shall want to look at a range of options to replicate the help that people currently receive and find a different and appropriate way to build that link. For example, in April of this year new arrangements on the pension side will come into force. They are designed to give extra help to carers.
That has a different link in place; it looks at whether somebody is caring for 20 hours a week or more. That can be certified in a whole range of ways by a health or social care professional. If changes are made to benefits the important message is that we would look to replicate the help in a different way.

Q928 Dr Naysmith: You can understand why this has been one of the most controversial aspects of the discussion and why people are concerned about it and it must be sorted out properly. We as MPs have lots of people writing to us about it. 

Ms Hobbs: I am sure your postbags have been busy on this issue. Very clear messages have been sent out which we hope have allayed some of the concerns that have been expressed. First, we have said that nobody who is currently receiving benefits will lose out; he or she will continue to receive the same level of cash support. Second, we have ruled out any changes to Disability Living Allowance for people under age 65. I believe that has helped to explain the position to people. We are not talking about taking help away from people without replacing it with something else. We want to make sure that the new national care service provides the same kind of help to the same people in appropriate ways.

Q929 Dr Naysmith: Mr Behan, is there anything that you want to add?

Mr Behan: As Ms Hobbs says, the basis of the assessments in social care undertaken under the fair access to care services criteria looks at people's needs. One of the essential differences in the assessment of benefits is the issue of risk. You could have two people who need help with, say, washing and dressing but the risk posed for one person might be different from that posed to the other. I go back to your very first question about the availability of informal carers. In a sense they identify some of the differences between the two assessment systems, but the vision in the Green Paper is of an integrated assessment system that draws together assessments undertaken under the benefits system and those undertaken under the care system.

Andy Burnham: The proposal is to have an independent expert group to develop the integrated assessment that takes stuff from the benefits side and the local authority side.

Q930 Sandra Gidley: We have just heard that disability benefit reform has been ruled out for those under 65, but that still leaves older people. Why does age matter in this?

Andy Burnham: For the reason I gave just a moment ago. Obviously, we are looking at a reform that deals with the cost of growing older. The DLA system as I understand it is a different benefit; essentially, it is one that recognises that disabled people do not have the same earning potential throughout their lives. There is very soundly-based research that often they receive about 70% of the average income of somebody else. That system works for that reason and it does a different job; it is compensating people because they have not had the same earning opportunities, whereas the costs of growing older are different. People work throughout their lives and develop assets. As they grow older they have care needs. I believe there is a consensus that there should be some kind of partnership between the individual and the state to deal with those needs as they get older, hence the difference.

Q931 Sandra Gidley: But there are a number of allegations of age discrimination in social care. Will not the abolition of disability benefit for older people just compound that?

Andy Burnham: I certainly hope not. We made a very powerful statement and we hope that social care and the NHS will be subject to the provisions of the Equality Act by 2012. That was not necessarily an easy thing to do. It is not a token statement but a very important one. As we are an aging society it is absolutely right that we should have equality of treatment for all people. I agree that vigilance on this very issue is required, but the principal argument is that this is what we should do. In terms of the age range proposals in the Green Paper our legal advice is that they are not discriminatory in any way.

Q932 Sandra Gidley: Even taking into account the proposed change in legislation?

Andy Burnham: Yes.

Q933 Sandra Gidley: Mr Behan, Professor Ruth Hancock told us that 86% of older people receiving disability benefits receive no social care services and less well off people are more likely to claim these benefits. Would not any proposed changes penalise such people by focusing all the resources on the very high-dependency cases currently served by the social care system? Obviously, if you are trying to prevent people from having more acute needs later that seems to be a bit of a problem.

Mr Behan: No. As a result of the consultation officials in the Department of Health and the Department for Work and Pensions continue to have exactly these debates about the distributional effects. In essence what we have accepted is that Attendance Allowance is used by some people to make arrangements to be supported often outside of the social care system and the support does maintain their independence. That is the root of the answer given earlier by Ms Hobbs about no one losing out and ensuring that in any future system that support continues to be available. We have taken cognisance of the fact that Attendance Allowance is used to provide a low level of support. We continue to work on the “distributional effects” of the changes proposed.

Andy Burnham: I believe you have taken evidence from Imelda Redmond to the effect that some people receive benefits and council support; some receive either one or the other; and some receive neither. That is the essence of the problem here: there is one system looked after by Ms Hobbs’ department that has one way of looking at things; we have a different set of criteria that councils and local authorities apply, and in the middle there is a level of unmet need. The essence of the reform is to match money to need and reduce the level of unmet need.
Q934 Sandra Gidley: Is the idea to help people who probably do not get what they should get from the system at the moment?
Andy Burnham: What we are trying to do is match resources to need in a better way.

Q935 Charlotte Atkins: A good deal of fear has been created on disability benefits. You have said there will be no cash losers but is not one of the issues in relation to Disability Living Allowance and Attendance Allowance that they are not means-tested and therefore people see it as a sort of buffer? There is real concern about any change in that system. People know that they have the Attendance Allowance and Disability Living Allowance and they are not means-tested in any way. What would be the transitional arrangements? What do you plan to do if you look to change the system? A huge amount of fear has been created, some politically generated, and this is perhaps your opportunity to make it clear to people that this is not at risk and any transitional arrangements will not put them in a situation where they will have to be means-tested for these sorts of benefits?
Andy Burnham: I agree that some very vulnerable people have been frightened by scurrilous and unacceptable campaigns. All they have said is that benefits will be withdrawn but they have not explained the situation. It is not as if it is to be taken away. That is fundamentally unacceptable. We can only have this debate about reforming social care if there is a measure of moderation in the language of all parties; otherwise, we will not get past first base and it will raise anxieties. The bodies interviewed have said that there are anxieties among their wider membership which I fully understand. Do not raise those anxieties unnecessarily by misrepresenting the reforms as I think the Conservative campaign has done. It is one thing to disagree with the principles that we are building here; it is quite another to suggest that the benefits are taken away and nothing comes back. You say this is my opportunity to explain it. The only reason for doing this is better to support more vulnerable people. We are not on a Treasury mission to take it away; we are intending to do a better job of looking after vulnerable people in our society. We believe that we could do a better job if there was a more integrated approach between the benefits side and the social care side. In doing that we believe we can empower those people and give them greater control over their lives. It is deeply disappointing to see these kinds of campaigns being run. I do not mind meeting any of those bodies who say that there is concern among their members and ask us to tell them more about it. Legitimately, we felt that the “no cash losers” side of the reform was an important thing to say because those are fair concerns and people need answers to that question, but it is quite another to have “take away your benefits” campaigns.

Q936 Charlotte Atkins: Can you guarantee that in future no one who qualifies for disability benefits under the current system will receive less under the new one?

Andy Burnham: At the time of reform I have said that no existing recipient of DLA or AA will receive any less cash support, nor will they lose any control over their ability to spend that. To say more than that is to second-guess the White Paper. At this stage a Green Paper looks at different ways of doing it. I am not being evasive or reluctant to tell you what we have in mind; it is simply that we are not at that point. If all parties are serious about reforming social care in my view we cannot completely exclude from it Attendance Allowance because then you are not building a solution that is a full reform of the system; you are not providing even a sticking plaster. Either the Conservative Party is a proper player in this reform and wants a serious debate about it or it mounts cheap, scurrilous campaigns running up to the election. It must choose which it wants to do.

Mr Bone: I am certainly not here to indulge in party politics; that is not the purpose of this Select Committee. I think the Secretary of State said that effectively there would not be any losers in terms of existing recipients within the system. That implies that of those people who would qualify in future there will be winners but also losers, so in some circumstances people will be worse off in future.

Q937 Chairman: I thought the Secretary of State said he would be second-guessing the outcome of the White Paper if he went into any detail about the future, which is quite a reasonable thing to say in the circumstances.
Andy Burnham: Earlier Charlotte Atkins asked whether the partnership option should be set up. Should not the minimum entitlement for everybody be set higher? That is a very fair question. That is a policy choice, is it not? You could set the minimum entitlement for everybody at or above the level at which people could not receive either AA or DLA. You could make that choice, but please do not say I am implying anything. We have not made those decisions.

Q938 Mr Bone: Secretary of State, I did not mean to put words into your mouth. Having listened to what you said I thought that was the implication of it. I now understand what you are saying is that no decisions have been made on that point.
Andy Burnham: Of course not. We have had a Green Paper and consultation. I have said that we are working towards the White Paper when the government will make firm proposals for reform, but we are not there yet.

Q939 Dr Naysmith: You want to bring cash benefits into social care and replace social care services with cash payments. Would it not, therefore, make much more sense to transfer responsibility for social care from the Department of Health to the Department for Work and Pensions?
Andy Burnham: It is true that the changes are happening more on our side in many ways, in that more and more social care support replicates cash benefits. There is a merger going on here, is there not? It is this side that is coming closer to the other. Perhaps a weakness in the Green Paper was that the
of and around that is a matter for departmentally-controlled spending, but you make a very good point. My old Treasury days come back to me now and that was stuff I had to know in detail.

Q942 Dr Taylor: Why have you given up on individual budgets which combined local authority social care money and other funding streams?

Andy Burnham: We certainly have not. Ms Hobbs may be able to say more about the right to control work that is going on for which DWP has legislated.

Q943 Dr Taylor: So, you have not given up on the idea?

Ms Hobbs: Certainly not. The principles running through and across government in this sense are about giving people the right to control, bringing together different funding streams, for which parliament legislated in the Welfare Reform Bill last year. That will bring together a wide range of funding streams for disabled people, including access to employment and that kind of thing. Trailblazers will be up and running in October of this year. We shall be working closely with the Department of Health to align that with personal care funding. When one goes out and about one is struck by how crazy the current system is and how difficult it can be for people, whether they are of working age or are pensioners, to find their way round this deeply confusing system.

Q944 Dr Taylor: Are you just giving up the words, because “individual budgets” as opposed to “personal budgets” were very confusing without explanation?

Ms Hobbs: I certainly agree with that.

Q945 Dr Taylor: So, you will have personal budgets but with local authority social care funding and other public funding streams coming into that?

Ms Hobbs: What we have said in the Green Paper is that at the heart of a national care service is the principle of personal budgets. Basically, we are saying that people will be able to decide how they spend the money in a way that meets their needs and keeps them independent. There is a lot about words here.

Andy Burnham: When one talks of personal budgets, individual budgets and direct payments people’s eyes start to glaze over. This is a very interesting side of public service reform that will play out not necessarily immediately but over the next 20 years. When you look at the effect of our health personal budgets pilot the intention is to merge it with direct payments in social care, employment and elsewhere, but here you cannot run before you can walk. The implications of all of this are pretty vast. This is the way public service reform is going. I believe this degree of empowerment of the individual who can call down the support he or she needs to deal with a range of needs is very exciting and is now genuinely opening up. The momentum is there in all public services to go this way.
Q946 Dr Taylor: So, somebody could have his personal budget supplemented by money from the Independent Living Fund, for example?

Andy Burnham: Yes.

Q947 Dr Taylor: So, it is just words?

Andy Burnham: Yes.

Q948 Charlotte Atkins: The implications for council services are quite great. I believe that Oldham is one of the first councils to start closing down the services and simply telling people they should be using their individual budgets and do the commissioning themselves. It has done that in respect of dance classes for people with learning disabilities, but the same could be extended to day centres, for example. If you want to attend a day centre you can use your individual budget to buy into it. Do you believe that is acceptable, or should those sorts of services be ring-fenced given the difficulty of individuals being able to get sufficient agreement across a wide range of people who use those services, or will it just be used by councils as a way to close down services and confine people 24/7 to their own homes and get services delivered to their homes?

Andy Burnham: You have just put your finger on why we should not do what Dr Naysmith invited me to do and hand it all over to DWP. There will be a role for local government to make sure there is still a mixed economy in any locality to cater for the range of needs. Some of that can quite properly be in-house, direct provision by the council. For that reason we need to proceed in this area with caution. We have all agreed in principle that it is the right thing to do but there could be a destabilising effect on collective services. Some people are considered valuable to them and if you disturb the critical mass of people who use that it may disappear. For me the council has to hold the ring; it must manage the process and respond to what people are saying they want. The end result is that people will speak and get the services they look for. You quoted the example of Oldham where there are examples of good practice. You might say that traditional collective services have declined but they very much encourage the development of new collective services. Oldham works with faith groups to develop services that are more sensitive to the needs of the community. That is an interesting thing. That is the kind of change you will probably see in all local authority areas. The best councils will encourage those new forms of collective provision that people in those area want. That is why the role of local government is still important. As Sir Jeremy Beecham told you, there will be local circumstances and needs that councils will be well placed to detect and then help provide.

Q949 Charlotte Atkins: In one case with which I am familiar a young girl with learning disabilities received direct payments. She was being taken out to shop every day. Some 18 year-olds would love that but she did not. She wanted to access the local day centre but was told that because she had direct payments she could not do so. I managed to get that overturned but it was a big battle. It seems crazy to rush headlong down the direct payments route which can work brilliantly for lots of people, but if those people are then confined 24/7 to their homes because the community out there does not meet that need and it does not feel adequately equipped to access community services in terms of social interaction you can end up losing valuable day centres. Some are good and some are bad but they can be made much more focused and inclusive. We may have a situation where the individual rules and we lose that collective provision which can be so important to keep people out of acute care.

Andy Burnham: I think you make a very important and genuinely difficult point. It will be for councils to manage that tension. You say “rush headlong”. In some ways I believe that progress towards direct payments is not as strong as it might be in some places. Arguably, they tend not to face the new world and should perhaps be cracking on with it to a greater extent. Some authorities, for example Harrow, are making great strides on this agenda and help to build that new market. There is the emergence of new market places. I do not know whether the Committee is aware of a service called Shop for Support. It is a place where people can go and see the whole range of accredited services available to them. User-friendly and easy-to-use services are now beginning to be built and are out there. Some councils are very proactive in using those services. I hear what you say, but not everybody in the end will want to have direct payments. On present figures of those for whom a personal budget has been assessed 20% take the whole thing as a direct payment; 50% will take their personal budget through traditionally provided services and 30% will mix and match, so some element of their care may come by way of a direct payment and the remaining value will take the form of traditionally provided support. It is managing that transition that is going to be, let me be honest, a difficult job for councils.

Q950 Charlotte Atkins: It has been suggested to us that councils should ring-fence some of these collective services like day centres. What is your position on that?

Andy Burnham: I think they should pay great attention to the views of users. They need to understand which of the services that are provided are liked, used and well loved and which ones people are not as keen on because they vote with their feet. Like the NHS, we must get better at measuring patient satisfaction. The same applies in this field. If very important services are jeopardised by people who remove themselves from them the council needs to be on top of those issues, but we should not do their job for them. Understandably, the very strong argument that I hear from the LGA is that there needs to be a council role in the national care service. This is part of what it would be. I cannot take over that role. If they want to
keep that role in commissioning and market-making it is absolutely right that they should do so; it is fine by me.

Q951 Sandra Gidley: Mr Behan, Can you clarify exactly those things on which direct payments can be spent? How should we monitor the spending to make sure taxpayers’ money is spent appropriately?  
Mr Behan: Probably this question comes from the more controversial aspects of direct payment spending. When people use direct payment very often they do so to procure quite traditional forms of service. There is very little evidence that these are being misused by people for reasons other than those things that help them to be supported. We have had direct payments since 1996 and they were in large part born out of the disability movement. In relation to Charlotte Atkins’ questions, interestingly enough they rejected the notion that group living was good for them and said they could do a better job of looking after themselves if we gave them the money. Out of that the direct payment legislation was born. The evidence is that since 1996 people in receipt of direct payment have used it to arrange practical help, very often to assist people to go to work and to continue in employment. Some will arrange for personal care assistants to help them get ready in the morning to go to work. Often that practical assistance is combined with money from the Independent Living Fund so they can continue to live independent and fulfilling lives. One interesting issue is how one breaks away from traditional services and begins to innovate. I spoke to a woman in Norfolk who was a mental health service user. She had been assessed to go back to a day care centre. She had earned her living earlier as an actress. She said she wanted to take this as a direct payment. Instead of going to a day centre she resumed acting classes. She used it to arrange practical help, very often to assist people to go to work and to continue in employment. Some will arrange for personal care assistants to help them get ready in the morning to go to work. Often that practical assistance is combined with money from the Independent Living Fund so they can continue to live independent and fulfilling lives.

Q952 Chairman: Not when they are playing Rotherham!
Mr Behan: That is an interesting story because the benefit from that related to his wife who provided care seven days a week. She would argue that £380 for a season ticket for Rochdale was cheaper than her husband going in for a day’s respite in that period. There was a trade-off here with the respite care that would otherwise have been paid. The season ticket was for the neighbour; the individual got in anyway because he was disabled. The respite was for his wife who hated football and wanted to go shopping. There was an interesting issue about where the benefit arose in that case. I believe we take an oversimplified view about some of this stuff. The other question is about monitoring in relation to this. This takes us back to the answer given by the Secretary of State about the ongoing responsibility of local authorities as custodians of public money at local level to ensure that it is properly spent. They continue to have care managers who will be involved in cases like this. Their role is to ensure that the needs of those individuals continue to be met and they have the fiduciary duty and responsibility as councils to ensure that that public money is spent in an appropriate way.

Q953 Sandra Gidley: The example of football is an old favourite. People with direct payments can choose to spend their money in that way, but if people receive services directly and want something similar should they be allowed to do so?
Mr Behan: The care plan in that particular case talked about the need for respite. The creativity and innovation arose when the individual was not sent to a residential unit for respite and the question was: how could this be done in a different way? The plan was to get respite, not to give somebody £300 for a season ticket; it was related to the individual’s need. The innovation arose in meeting the need.

Q954 Sandra Gidley: I appreciate that the carer got a much greater benefit; it is a win-win situation. Up to now direct payments cannot be spent on in-house council services. Can a personal budget paid in cash be spent in that way?
Mr Behan: Very often it is a notional personal budget. Thirty per cent of people take their services somewhere between that innovative approach where they make a direct payment and much more traditional forms of assistance. A personal budget can be a notional sum; it is not people getting cash into their pockets with which they then purchase
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services, which is what a direct payment is: it is a notional budget and it can take the form of a direct payment in part and then support in a much more traditional way, so the answer is: yes, you can use a personal budget to procure council services.

Q955 Dr Naysmith: The final question is a policy question in a way. Regulation and safeguarding have been increased in directly-provided and commissioned services, yet they are totally absent where people use direct payments to employ personal assistants. Should it not be consistent one way or the other, and what are the general lessons from this for the regulatory implications of personalising social care? What are you doing to address them?

Andy Burnham: There certainly are implications, but I do not believe people want to thank us for the long reach of bureaucracy into their homes, friends and family who are known and trusted. As in the Rochdale example, they are people the individual knows. We want to get that balance right and it is an area to be watched as the matter unfolds, but I do not think one would immediately say there must be a vetting and barring scheme and all the things that that entails.

Q956 Dr Naysmith: Do you think there might be regulatory implications?

Andy Burnham: There could be. It is an area where one wants to proceed with caution but again it points to the oversight role of the local authority to make sure that nobody’s safety is compromised or put at risk by any care package that they may decide for themselves.

Chairman: Thank you very much.
Written evidence

Further memorandum by the Parkinson’s Disease Society (SC 19A)

SOCIAL CARE

INTRODUCTION

In our Memorandum of Evidence the PDS stated that we did not have a preference for the future funding of long-term residential and domiciliary care, but that we were in the process of surveying members for their preferences on this issue and would be happy to submit the results as additional evidence to the Inquiry.

We are pleased to attach the results of this survey, which was completed by 605 people with Parkinson’s between July and October 2009.

In addition to the three models for funding care favoured by the government in the Green Paper, we also asked people’s views on funding care through an increase in tax or National Insurance and included an additional question on this issue. Respondents indicated strong support for a tax funded model, with 57% favouring this option. Of the three models proposed by government the Comprehensive model was most popular, favoured by 22%.

The survey also asked people’s views on the proposal to abolish Attendance Allowance (AA) to help fund care and support. Just 5% of respondents supported the proposal for AA to be subsumed into the funding for a National Care Service, 62% did not wish Attendance Allowance to be abolished under any circumstances, 7% would be happy for a reduction in AA in light of improved support and 26% would be happy for AA to be abolished if all their disability-related costs were met.

We also asked whether accommodation costs in residential care should be covered by the National Care Service. A clear majority (78%) of respondents were opposed to accommodation costs being excluded from a National Care Service.

VIEWS OF PARKINSON’S DISEASE SOCIETY (PDS) SUPPORTERS ON HOW A NATIONAL CARE SERVICE SHOULD BE FUNDED

Members and branches were sent two questionnaires, one on how care and support should be funded in the future, which received 605 responses, and one on what a National Care Service should look like, which received 271 responses.

Of the 605 respondents to the funding questionnaire, 306 respondents indicated that they were people with Parkinson’s, 163 were carers, with fifty other respondents, the majority of whom were former carers. There was virtually no difference between the responses received from people with Parkinson’s, carers and other respondents and the figures quoted below are based on all responses received. The findings from the survey are:

Funding models
— 57% favoured funding out of tax or National Insurance.
— 22% favoured the Comprehensive model.
— 13% preferred an insurance model.
— 9% favoured the Partnership model.

Should the National Care Service cover accommodation costs in residential care?
— 78% believed that accommodation costs in residential care should be included in the National Care Service.

Proposals to abolish Attendance Allowance (AA)
— 62% stated that Attendance Allowance should not be abolished under any circumstances.
— 5% would be happy for AA to be abolished and incorporated into the funding of a National Care Service.
— 7% would be happy reduction in Attendance Allowance if the majority of their care needs were met by a National Care Service.
— 26% would support the abolition of AA if all their care costs were met by a National Care Service.

Val Buxton
Director, Policy, Campaigns and Information
Parkinson’s Disease Society

November 2009
Memorandum by Scope (SC 51)

SOCIAL CARE

1. ABOUT SCOPE

1.1 Scope is a major disability organisation whose aim is that disabled people achieve equality and enjoy full human rights. We provide a range of transition, residential care, domiciliary care and empowerment in the community services to disabled people. Many of the disabled people we support have complex needs. We welcome the chance to respond to this consultation as social care is an integral and essential part of our stakeholders’ lives.

1.2 The changing demographics of Britain mean that demand for social care provision will inevitably increase, which will put significant strain on resources. As well as the challenges brought by an aging population, advances in technology mean that more young people with complex needs are living for longer into their adulthood (it is estimated that between 2002 and 2029, the older, disabled population will increase by 40%)

1.3 There are currently almost two million people receiving social care in England and this may rise by approximately 1.7 million by 2029. For many disabled people effective and timely social care is the difference between engagement and isolation, independence and dependency. Social care and support is essential for many disabled people to lead full and rewarding lives, however previous proposals on social care reform in England have not fully considered the lives of disabled people, nor meaningfully addressed the substantial barrier that disabled people still face in accessing appropriate, effective and timely social care and support.

1.4 We have welcomed a number of key aspects of the Government’s Green Paper; in particular the proposals for greater consistency of care and support through a single assessment, joined-up working, a greater emphasis on personalisation and information, advice and advocacy. However we remain disappointed that a number of substantive barriers to fair access to social care have not been sufficiently resolved. We have outlined our outstanding concerns in this document.

2. EXECUTIVE SUMMARY

2.1 Whilst the proposals in the Green Paper take some important steps towards social care reform, there is still a lack of detail on the practicalities of reform and a lack of consideration of disabled people; particularly those of working age. We still have outstanding concerns about the restrictions and inconsistencies of eligibility criteria, which are exacerbated by the limitation on portability posed by the retention of Ordinary Residence rules.

2.2 Whilst the proposals do not explicitly state the submergence of DLA and AA in the general social care funding pot, the Government needs to give both reassurance and commitment to those three million disabled people who would automatically be worse off if such a direction were taken. Finally, information, advice and advocacy services need to be effectively resourced in order to ensure that disabled people and their families can take full advantage of the personalisation agenda. Brokerage in particular could be an effective way of stimulating and shaping a personalised market.

3. PORTABILITY AND ORDINARY RESIDENCE

3.1 The absence of an ability to move your support package from one authority to another without your level of support being reduced (portability) remains a significant barrier for disabled people. We have welcomed proposals from the Green Paper which have aimed to resolve this by suggesting a national needs assessment which can be transferred from one authority to another and an entitlement to the same proportion of care and support costs paid for wherever one lives in England. Whilst this will be a step towards resolving the issue of portability, it does not remove the core of the problem: ordinary residence rules. Ordinary residence rules govern where a person is considered to be resident and who is responsible for

2 Personal Social Services Research Unit (2005) Long-Term Care Expenditure for Older People, Projections to 2022 for Great Britain: http://www.pssru.ac.uk/pdf/dp%2020252.pdf
6 Approximately 2.9 million people are receiving these benefits and are not receiving social care. Figure extrapolated from DWP (2009) Quarterly Statistics Summary: http://www.dwp.gov.uk/docs/stats-summary-aug2009.pdf
7 Ibid
funding their support package. It is estimated that over 500 people are caught up in ordinary residence disputes at any one time and that nearly 20,000 people could be adversely affected in the longer term. Until these rules are addressed, local authorities will continue to dispute funding responsibilities, and disabled people’s freedom of movement will continue to be restricted. The case study below demonstrates how ordinary residence is preventing independent living:

4. **Case Study — Stuart**

4.1 Stuart is 30 years of age and has a learning disability. He is funded “out of area” and shares a flat with three other people. He works at a garden centre and bakery and has a Saturday job in a café. Stuart has a good social life, he knows his way around his local community, and has made major strides in developing his confidence and independence.

Stuart now wants to move into a place of his own. He has found a flat, close to where he is currently living. This is ideal, since it will enable him to maintain his existing friendships and networks and he knows his way around the local area. Stuart will claim housing benefit but will need additional funding from the local authority for his personal support.

4.2 However, Stuart has now learned that his move may not be possible. His placing authority has told him that he will now become an ordinary resident in the authority where he wishes to live, and no longer eligible for funding by them. The authority he wishes to live in say that they will not fund his care until he has been resident in his own flat, claiming housing benefit, for six months. So Stuart is caught up in a Catch-22 situation; he can’t move into his flat and claim housing benefit until his support package has been agreed, and he can’t have a support package until he has been living in his flat for six months. Whilst the two authorities are in dispute, neither is prepared to carry out an assessment of the support he will require in his new life.

4.3 Because of this, Stuart doesn’t know how much support he will receive if the new arrangements are agreed. He needs this information now if he is to make informed choices. The fear is that he will be assessed as needing less support than he needs and have his service levels cut just when he is feeling most vulnerable. Also there is no way back. It will be very hard for Stuart to reverse the move if for some reason it doesn’t work out. Even if his previous home is still in operation, the placement is likely to have been filled. The funding arrangements are not flexible enough to allow him to change his mind. This increases the worry for Stuart and his family at a time of major change. Stuart and his family are very upset by this. Stuart was looking forward to this new step in his life. He has found an ideal place to live and just needs support to enable him to do so.

4.4 Stuart’s case is just one of the hundreds of cases that third sector organisations, like Scope, deal with every year. As his case illustrates, Ordinary Residence rules need to be abolished to allow genuine freedom of movement. We are, therefore, disappointed that the recent ordinary residence consultation was seeking views on the guidance rather than the principle itself:

“[this consultation] is not seeking general comments on whether the concept of Ordinary residence is the most effective way of determining which local authority is responsible for the provision of social care. Nor is it seeking views on whether social care packages should be transferable from one local authority to another.”

4.5 From our subsequent correspondence with the Department of Health, we believe they may be seeking legal clarifications to the rules because of the substantial opposition to the rule. We would greatly encourage any substantive reform or removal of these rules and would be happy to offer any further clarification, advice or recommendations on this matter.

5. **Eligibility Criteria**

5.1 We are disappointed that the proposed changes in eligibility do not address the fact that eligibility criteria is too strict, leaving many disabled people in need of care receiving none. The problem is that councils are still able to interpret the eligibility criteria according to their level of resources, leading to a “rationing of services”. With 75% of councils now only providing care to people with “substantial” or “critical” needs we are seeing a rise in the number of people who do not qualify for care and support services. The rigid nature of Fair Access to Care Services (FACS) which is used to determine eligibility for social care also makes it extremely difficult to realise the model of self-directed support suggested by the personalisation agenda. We realize there is currently a consultation on revising the eligibility criteria and hope that it goes some way to addressing this area of concern.

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9 ibid
5.2 A national care service proposed by the Green Paper would go some way towards eliminating this inconsistency but it would depend how much discretion the local authorities would continue to have. All local authorities should use the eligibility criteria in a consistent way because this will ensure people receive the care they need while enjoying greater opportunities to work and travel in the local area. Increased social care will lessen isolation and alleviate the burden on the NHS. Social Return on Investment (SROI) is a useful framework within which to explore potential savings and map how early intervention can bring long-term benefits. For example, New Economics Foundation’s research has demonstrated that savings can be achieved to the local and wider public sector through early intervention in mental health.

5.3 As a transitional arrangement, the councils which only provide social care in the top two bands (substantial and critical) need to provide an infrastructure for signposting to information, advice and advocacy organisations. This could include a training brief for front-line professionals such as GPs and social workers so they can tell people where to find other means of support.

6. Retaining Disability Living Allowance and Attendance Allowance

6.1 The current concerns around eligibility could be further exacerbated by any proposal to remove important benefits, such as Disability Living Allowance (DLA) and Attendance Allowance (AA), as some disabled people will be left with no benefits and no social care despite requiring it. There are currently 2.87 million people receiving these benefits who are not receiving social care. If benefits such as AA and DLA were to be submerged into general social care funding, almost three million people would suffer, as would their families. These benefits provide vital support to disabled people. Many disabled people have told us that they rely on AA and DLA to meet the additional costs of living with an impairment or long-term health condition.

6.2 We believe that scrapping AA and/or DLA would have a very negative impact on many disabled and older people’s quality of life. They are the only disability related benefits which are not means-tested. A recent Select Committee report revealed that 29% of pensioners in households with one or more disabled adults who were not in receipt of disability benefits lived in poverty; in households where disability benefits were claimed, the figure was 11%.

7. Personalisation

7.1 We are encouraged by continued direction towards personalisation in social care and the proposals in the recent Green Paper to ensure that personal budgets will be available to all who want them. Devolved budgets can enhance the co-production of support services and ensure that disabled people contribute to making key decisions about their packages of support from the very start. However, the provision of information, advice and advocacy will be vital to ensuring the personalization agenda is successful. Whilst we want choice and control to be central to social care provision, we recognize that the choice needs to be informed for effective control to be realized.

7.2 Inadequate support to manage devolved budgets, levels of funding that are not adequate to buy the services people require, and a lack of suitable services or staff in the local area all prevent disabled people exercising genuine choice and control over their lives. Some local authorities have also chosen to limit what disabled people can spend their direct payments on personal/individual budget on. We believe that this goes against the ethos of independent living which demonstrates that disabled people are best placed to decide what support they need and who should provide it.

7.3 The funding and sustainability of effective and timely information, advice and advocacy services will be crucial to the meaningful realisation of the personalisation agenda. Importantly, there needs to be more collaboration between government and financial services to ensure that disabled people can access quality independent advice and appropriate financial services to enjoy the full benefits of a personalised budget.

7.4 In addition to appropriate advice services, the market will need to be further stimulated to create innovative, personalised services solutions that enable disabled people to have choice and control over their care and support. Research has suggested that an area of weakness within the civil service is developing innovative delivery models. Whilst Putting People First and the current Green Paper on social care reform contain high levels of innovation, they could go further in stimulating the personalised market marketplace. Below we have outlined three ways in which Scope has responded to the personalisation agenda and the increasing demand for these services by disabled people.

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8. **SCOPE INC**

8.1 Increasingly, personalisation is effective support in the individual’s own community. Scope Inclusion (Scope Inc) is a popular and well-respected articulation of this model because it offers opportunities for every aspect of an individual’s life—support at home, respite through a sitting service, as well as leisure and community support. The support provided by Scope Inc is based entirely around their needs—either in their family home or in a variety of social or community settings. The staff encourage disabled children and young adults to be as independent as possible. They offer outreach support, so that disabled children and young adults can take part in stimulating activities. They also assist with the development of new skills. They help disabled children and young adults to fully and equally participate in their favourite leisure activities and outings, alongside their non-disabled peers. So this could be things like swimming, bowling, going to the gym.

8.2 Involving a range of activities is important in ensuring that disabled people can participate in the same range of activities that non-disabled people can. For example, staff from Rutland House (our local specialist education establishment), part of Scope Inc, work in inter-disciplinary teams because this enables a more personalized service. Rutland’s broad aims include “to facilitate the holistic development of all pupils/students” and holistic multi-agency working will enable better use of personalized services. The North West Scope Inclusion Team offers a service of “includers” to help realize a vision of independence and inclusion. They work from person-centred plans to provide support in the most appropriate way, which maximises each person’s appropriate level of control over their own lives.

9. **CASE STUDY—BEN**

9.1 Ben is 23 years old, has complex needs and has lived in Scope’s Orchard Manor Transition Service for three years. This Transition Service is specially designed for young people aged 18–25 with the most complex care support and learning needs—those with combined physical and learning difficulties and additional sensory impairments. As Ben has neared the end of his time at Orchard Manor, he has worked with the Transition Coordinator and other staff to present his views on his life to his family and his Local Authority and to inform decision making regarding his future. Initially, it appeared that the placements likely to be available to Ben would be six to eight bed care homes. Ben would be able to have his own room and bathroom but would need to spend considerable time with and share facilities with other service users. This caused Ben anxiety. Scope agreed to alter a ground floor flat on the Orchard Manor site for Ben to use for a year after leaving the Transition Service. His Local Authority agreed to fund him in his new flat so that he will be able to make an informed decision about living in his own home in the wider community. When the time comes, people who know Ben well will support him to decide. Orchard Manor staff will help Ben to engage a staff team to meet his needs and to put in place an activity schedule to encourage his independence. Initially, he will be able to attend the Day Service on site but gradually will be encouraged to pursue his interests in the community.

9.2 The individual learning goals for young people with complex needs are increasingly seen as too “small” to attract funding for a college placement; while a care home cannot provide the stimulation and developmental learning opportunities that are vital if young people are to enjoy as much independence as possible later in their lives. The goal of Orchard Manor is to offer not only care, but to help young people develop as much independence as they are able. This marks it out as a distinctive service which could be used as a template for future transition services.

10. **BROKERAGE**

10.1 Brokerage is also an important issue for the future of social care and in particular, ensuring successful personalisation provision. Voluntary and community organisations are well-placed to fulfil this brokerage function, given that they often have distinctive knowledge of their client base and their families as well as the local areas. Appropriate brokerage also leads to market shaping meaning that people can take advantage of choice which is both informed and varied.

10.2 For example, Scope’s Suffolk Brokerage acts as an interface between the consumer and provider in social care. Scope is working in partnership with the Suffolk Aiming High team to develop and deliver a brokerage model that can work across Suffolk County Council’s 18 community clusters. Scope is responsible for matching the needs and aspirations of disabled children and young people by developing the market and creating a wide range of short break leisure and recreation opportunities. For example, the brokerage arrangement will ensure that there are sufficient short breaks across the range to meet potential demand at all levels. Scope has a robust quality control mechanism that will be applied across providers and activities to ensure they are safe and accessible. Scope regularly consults with disabled children and young people to ensure they are capturing up-to-date information about existing activities and also respond to changing need and interests. It has a collective understanding of all the services in Suffolk and the area now has ten times more integrated play activity than last year.

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17 For more information see http://www.scope.org.uk/education/scope-inclusion-team.php
11. **Further Areas for Exploration**

11.1 In order to fully understand the impact of the proposals of the future of social care and support, we recommend that the committee:

— Investigate the technicalities of implementing portable care packages as well as the benefits in radically reforming or abolishing Ordinary Residence rules.
— Investigate the ways in which the reform of eligibility criteria for social care and support can ensure better outcomes for disabled people as well and enabling a greater social return on investment for the state and local agencies.
— Visit either:
   — Scope Inc service, to explore the successful personalisation of support services;
   — Suffolk Brokerage, to consider third sector involvement in brokerage;
   — Orchard Manor, to investigate how personalisation can work in the context of young people with complex needs undergoing transition;
   — A local Disability Information Advice Line (DIAL) group to explore the importance of timely and appropriate information, advice and advocacy service to the success of personalisation.

October 2009

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**Memorandum by the Universities of Essex and East Anglia (SC 52)**

**SOCIAL CARE INQUIRY**

This evidence is submitted by Professor Stephen Pudney, Francesca Zantomio, ESRC Research Centre on Micro-Social Change, Institute for Social and Economic Research, University of Essex, and Professor Ruth Hancock, Dr Marcello Morciano, Health Economics Group, Faculty of Health, University of East Anglia.

**Summary**

Our evidence summarises emerging findings from our research on the role of cash benefits—Attendance Allowance (AA) and Disability Living Allowance (DLA)—in the support of older disabled people. It relates to people living in private households and excludes the care home population. The principal findings relevant to this inquiry are:

1. Claim behaviour for AA is strongly related to age, income and severity of disability. People with higher levels of age and disability, and lower levels of income, are more likely to make a claim for AA. Adjudication outcomes are, as expected, strongly related to disability.
2. Although not explicitly means-tested, AA/DLA payments display a degree of income targeting, since low-income people are more likely to have severe disability and are also more likely to make a claim. The degree of income-targeting is less than for Pension Credit, but still significant.
3. There is evidence of a large group of older people (at least 30% of the over-65s) who are not receiving AA but would be predicted to be successful, were they to make a claim.
4. Our analysis finds no evidence of significant numbers of older people receiving AA/DLA long-term without any accompanying health problem.
5. Receipt of AA/DLA and receipt of local authority social care services overlap only partially—there are many people who receive social care services who do not receive AA/DLA and vice versa.
6. A switch from a dual system of support (AA/DLA + local care services) to a unitary system providing only care services will greatly increase the uncertainty faced by potential applicants for support and the risk of uneven administration. Increased uncertainty poses a significant threat to take-up.

**Introduction**

1. The Social Care Green Paper (DH, 2009) suggests that as part of reforms to the long-term care funding system, consideration should be given to integrating some elements of disability benefits into the social care system. The idea of diverting (some of) the money spent on disability benefits into the social care system was first suggested in the 2006 King’s Fund Review of Social Care (Wanless, 2006).

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18 This evidence updates and expands on evidence submitted by Stephen Pudney to the Work and Pensions Select Committee’s recent Inquiry into Pensioner Poverty.
19 Corresponding author: Ruth Hancock: r.hancock@uea.ac.uk
2. In 2008 we provided an initial critique of the Wanless suggestion (Berthoud and Hancock, 2008). Currently we are part way through a project funded by the Nuffield Foundation on the Role and Effectiveness of Disability Benefits for Older People. Much of the evidence submitted here arises from emerging findings from that project.

BACKGROUND

3. The Green Paper puts forward a number of options for reforming the funding of social care. The front runner seems to be a “partnership” system in which everyone assessed as needing formal care services, would get some proportion (e.g. a quarter or a third) of their care costs met by the state without a means test. The remainder of their care costs, and the hotel costs of care home fees, would remain subject to a means test of some sort. The Green Paper also says:

“We think we should consider integrating some elements of disability benefits, for example Attendance Allowance, to create a new offer for individuals with care needs”. (p. 103)

and

“Whatever the outcome of the consultation, we want to ensure that the people receiving the benefits at the time of the reform would continue to receive an equivalent level of support and protection under a new and better care and support system” (p. 104).

4. Underpinning the Green Paper is analysis by Forder and Fernandez (2009) which is referred to in the Green Paper itself and in the Regulatory Impact Assessment (DH, 2009a). The latter provides some broad estimates of the costs of various options (including the partnership option) for “bringing new money” into the care and support system. These costs are:

“based on a system where Attendance Allowance had been drawn into care and support to create a new and better system.” (DH, 2009a, p. 37)

5. The way in which AA is assumed to have been drawn into the care and support system is not clear. There is no mention of drawing in DLA although a recent ministerial statement rules out the possibility of DLA being withdrawn for people aged under 65.

6. The rationale for diverting resources spent on disability benefits into the care system seems to be that these benefits are less well targeted than social care, although neither the Green Paper nor the 2006 Wanless report offers evidence on the targeting of social care services. Some analysis is presented in Forder and Fernandez (2009), which questions the targeting of AA and DLA, concluding that a relatively large number of people, despite having no limitations in activities of daily living, receive AA (p. 12) and that “very wealthy people still show a significant propensity to claim [AA]” (p. 13). They analyse data from the English Longitudinal Study on Ageing (ELSA) and the British Household Panel Survey (BHPS), although we have not found precise details of their analysis in the public domain.

AIMS OF OUR RESEARCH

7. Berthoud and Hancock (2008) undertook an initial analysis of the Family Resources Survey (FRS) which showed disability benefits to be received mainly by people whose incomes, before these disability benefits, are in the lower parts of the income distribution.

8. Our current research concerns people aged 65 and over and so focuses mainly on Attendance Allowance (AA), although some of what follows refers also to DLA paid to people aged 65 and over.

We aim to answer the following questions:

— How does the AA system work in practice in terms of the achieved pattern of delivery of benefit to potential claimants?

— Does the chance of success of a claim for AA depend as strongly on measured disability as we would expect (i.e. how effective is the assessment process)? Is the probability of receiving AA for people with no disabilities really as high as has sometimes been suggested?

— What are the influences on claim behaviour? In particular, what are the personal characteristics and circumstances that distinguish AA recipients from potential beneficiaries who do not claim?

— What would be the most likely impacts of our emerging findings from that project on the existing provision of social care services?

20 The work was supported by the Nuffield Foundation, a charitable trust established by Lord Nuffield. Its widest charitable objective is “the advancement of social well-being”. The Foundation has long had an interest in social welfare and has supported this project to stimulate public discussion and policy development. Support from the ESRC through the Research Centre on Micro-social Change (MiSoC) at the University of Essex is also acknowledged. The British Household Panel Survey data were originally collected by MiSoC (now incorporated within the Institute for Social and Economic Research) and made available through the UK Data Archive. Data from the English Longitudinal Study of Ageing (ELSA), made available through the UK Data Archive, were developed by researchers based at University College London, the Institute for Fiscal Studies and the National Centre for Social Research. Material from the Family Resources Survey, made available from the Office for National Statistics via the UK Data Archive, has been used with permission. All responsibility for data analysis and interpretation, and views expressed, rests with the authors.


22 Of the 2.4m people aged 65+ receiving either AA or DLA in February 2009, 0.8m (i.e. a third) received DLA (statistics obtained using the DWP tabulator tool, available at http://83.244.183.180/100pc/dla/tabtool_dla.html.
— Are many potentially successful AA claims not pursued by the potential claimants?
— Although AA is not means tested, is there evidence that lower income people are more likely to claim than higher income people with similar disability levels? Does the nature of claimant behaviour mean that the AA system in fact mimics the effects of means-testing?
— Are there arguments in favour of having two separate systems—disability benefits and social care services—particularly as both entail uncertainty in outcomes?

Our research uses household survey data, so is confined to people living in private households. It excludes older people living in care homes.

9. Behavioural theories which regard benefit claims as a form of “rational” decision-making behaviour predict that:
   (i) People with higher income will be less likely to claim AA;
   (ii) People with more severe disability will be more likely to claim AA unless
      — disability makes it much more difficult to negotiate the claims process and/or:
      — disability reduces the individual’s capacity to benefit from additional cash income (eg because of the difficulty of managing the process of buying care).

Point (i) means that the flat-rate non-means-tested AA system may mimic a means-tested benefit to some degree. Point (ii) means that, should we find claim behaviour to be unaffected by the severity of disability, it would suggest a problem of poor targeting of AA, in the sense that disability in itself makes the process of claiming and using the benefit more difficult.

10. Research on this issue is difficult since no large-scale data source tells us everything we need to know. Sources like the ELSA, the BHPS and the FRS tell us about receipt of AA, but not about unsuccessful claims or unpursued potential awards. The DWP’s administrative records also tell us nothing about unpursued potential awards and they contain no information on factors like income, which are not required on the AA application form.

11. Our research uses two new approaches. First it combines FRS and administrative data to distinguish the separate roles of individual claim behaviour and the DWP assessment process. Secondly, it applies a statistical method23 which allows us to uncover the underlying level of disability, on a continuous spectrum, that results in difficulties with activities etc. which respondents report in surveys. It exploits all the available measures of disability in the surveys. We can then examine how AA receipt is related to this underlying level of disability and to other personal characteristics, including income. We have applied this method to ELSA, the BHPS and FRS to see whether the results are consistent across these three sources.

12. Uncertainties are inherent in assessments of eligibility for disability benefits and for care services. Two different assessors processing the same application in the same circumstances may often—quite reasonably—reach different conclusions about eligibility for benefits or care. We therefore offer a preliminary and illustrative assessment of the consequences of these uncertainties in a single system of assessment for care services rather than the separate systems we now have for disability benefits and care services.

EMERGING FINDINGS ON CLAIMING AND BEING AWARDED ATTENDANCE ALLOWANCE

Our main findings, presented in detail in a technical paper (Pudney 2009), are the following:

Finding 1. The probability of an AA claim being upheld is strongly related to the claimant’s severity of disability (expressed in terms of the number and nature of activities that are affected by impairments), so that eligibility adjudications do seem to be responsive to care needs.

Finding 2. Despite its formal design as a non-means-tested, largely flat-rate, benefit, AA is essentially self-means-tested in the sense that people who could be seen as having greater general need (ie older and with lower incomes) have higher probabilities of claiming AA, for any given level of disability.

Finding 3. Claim behaviour is strongly influenced by the severity of disability. We predict a much higher probability that a claim for AA will be made by people who are severely affected by disability. This tends to support the view that targeting is reasonably good in the sense that there are not large numbers of frivolous claims, and the “hassle” of making a claim and the difficulty of using additional cash income effectively do not become overwhelming for higher-disability groups. This is, however, only a statistical statement about average behaviour for groups of people—there will still exist many particular individuals who suffer because they are put off from claiming by the hassle involved, or by worries about using a cash allowance to pay for care.

Finding 4. Targeting appears to be some way short of the picture suggested by the rules of the AA system. There is evidence of a large group of potential AA awards which are not made, because no claim is put forward. At least a third of over-65s in the household population who are not receiving disability benefit would be predicted to be successful if they were to make a claim. This is a striking

23 Latent variable structural equation modelling.
finding which is supported by the fact that, of AA/DLA non-recipients in the FRS, 37% report the existence of disability resulting in difficulties in at least one area of life. Even among those so disabled as to be receiving care day and night, fewer than 60% are recorded by the survey as receiving AA. Similar, or even lower, rates of AA receipt are observed for care recipients in ELSA and the BHPS. The debate on reform of disability benefits and the care system appears to have neglected the question of the extent to which the system deters potentially eligible claimants from coming forward. We have found no research into how many people who would be judged entitled to state supported social care, fail to come forward for it.

EMERGING FINDINGS ON HOW AA/DLA RECEIPT IS RELATED TO DISABILITY AND INCOME

A forthcoming discussion paper (Morciano et al., forthcoming) describes our analysis in detail. Emerging findings are:

Finding 5. Because high-income people have a lower propensity to claim AA and a lower incidence of severe disability, there is a degree of targeting of AA towards low-income people—although this is less pronounced than for the explicitly means-tested Pension Credit system. For example, around 25% of people in the bottom fifth of the distribution of original equivalent income\(^{24}\) receive AA, compared with just over 50% for Pension Credit (Figure 1).

Figure 1

RATES OF RECEIPT OF PENSION CREDIT AND ATTENDANCE ALLOWANCE/DISABILITY LIVING ALLOWANCE AMONGST PEOPLE AGED 65+, AGAINST EQUIVALENT INCOME BEFORE MEANS-TESTED AND DISABILITY BENEFITS (FAMILY RESOURCES SURVEY 2002/03–2004/05).

Finding 6. Of those receiving any AA, and taking account of the level of disability, people on lower incomes and those without any savings are more likely to be receiving the higher than the lower rate of AA. Thus, within the group of AA recipients, there is evidence of further income targeting in the pattern of benefit receipt.

Finding 7. When we consider not only limitations in activities of daily living, but also all the other indicators of disability and ill-health available in ELSA, we find negligible numbers of AA/DLA recipients who are healthy on all measures. In the 2002–03 wave of ELSA, we identified 154 respondents aged 65+ (corresponding to approximately 220 thousand in the population of England as a whole) who reported income from AA/DLA but reported no difficulties in activities of daily living. When people who have limitations in instrumental activities of daily living (such as preparing a hot meal, doing work around the house or garden, taking medications) and difficulties in domains of life (such as walking 100 yards, climbing stairs without resting, getting up form a chair after sitting for long periods) are included this number falls to 26. Of these, 20

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\(^{24}\) Income before means-tested and disability benefits, assuming that the cost of living for couples is 1.6 times that for single people.
Ev 176 Health Committee: Evidence

Report at least one of the following medical conditions: high blood pressure or hypertension; diabetes; chronic lung disease such as chronic bronchitis or emphysema, arthritis and/or osteoporosis; cancer or malignant tumour. Of the six remaining cases, two were not receiving AA/DLA at the next wave of ELSA. Consequently, there is no evidence from this analysis of significant numbers of people receiving AA/DLA long term without an accompanying health problem.

**Finding 8.** Receipt of AA/DLA is strongly related to disability. The estimated probability of receipt for people in the lowest 20% of the distribution of the underlying disability index is zero, but this rises steeply in the top 20% of the distribution (Figure 2).

**Figure 2**

RECEIPT OF AA/DLA AMONG PEOPLE AGED 65+ AGAINST DECILE OF DISABILITY, FRS, ELSA, BHPS 2002–03.

13. Our preliminary interpretation of these findings is that they support the view that there is a role for cash benefits like Attendance Allowance within the system of support for older disabled people. There is a significant problem of delivery of these benefits to those who might qualify for them, but we see no reason to believe that a system based purely on direct provision of care services would be more effective in its delivery. The strong disability gradient of claim behaviour suggests that a large proportion of potential beneficiaries do see cash benefits as a valuable form of support which is worth the considerable effort of claiming.

14. Evidence from FRS data suggests that the systems of AA/DLA and LA home care are quite different in their coverage of the older disabled population. Of those who receive LA home care, 34% receive no DLA/AA, while among DLA/AA recipients, 86% receive no LA care services. Of people who are receiving night-and-day care from any source, 24% receive no DLA/AA payments and 87% receive no LA care services. It is sometimes suggested that the AA/DLA system is less well targeted than LA support, so that shifting of resources from cash benefits to LA care would improve targeting of support for older disabled people. This simple argument is not supported by the survey evidence, which suggests that LA care and AA/DLA payments are differently targeted relative to need—neither of them perfectly so.

15. What would be the consequence of removing the DLA/AA cash benefits and using the savings to increase LA home care provision? This question cannot be answered properly without consideration of uncertainties—both systemic and uncertainties faced by individuals in need of support. The policy debate and research on which it rests has largely neglected the important issue of risk.

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25 Analysis of 2002/03–2004/05 Family Resources Survey, over-65s.
16. **Individual uncertainty (risk)** arises from the variations inherent in any disability assessment procedure, where “need” and “disability” are matters of judgement. To a disabled person, applying for LA care and also for AA/DLA is like buying two lottery tickets. Compared to a unitary system with a single assessment procedure, this is equivalent to spreading your resources across two tickets rather than staking it all on one—risk is higher in a unitary system. Annex I sets out a detailed example of a typical case under realistic assumptions about the rates of error in LA and AA eligibility assessments. If AA/DLA is abolished and re-directed to LA care (a “unitary” system), the typical disabled person’s risk of receiving no support at all rises more than sixfold. The general level of uncertainty rises by over 20%. There may be some administrative cost savings in switching from a dual-support system to a unitary system, but the accompanying increase in the uncertainty faced by potential applicants should be set against those savings. The increased uncertainty will, in turn, reduce the likelihood that disabled people will choose to apply for support.

17. Increased **systemic risk** comes from the transfer of responsibilities from two bodies (DWP and the LA) to a single care provider (the LA). Arguably, public scrutiny of the political decisions on disability policy is stronger at the national (DWP) level than at the local (LA) level. Consequently, the policy risk is greater under a local unitary system. Moreover, there is evidence of considerable variation across LAs in the resourcing of care services and the way that eligibility assessments are carried out (Commission for Social Care Inspectorate, 2008) so a transfer of support from a uniform national source to a variable local source will result in greater inequality of treatment (the “postcode lottery”). This systemic aspect of risk is hard to quantify, but it is potentially very important.

**Finding 12.** A reform that moves from the current dual benefit + care system to a unitary care-only system is likely to lead to a significant increase in the uncertainty facing potential applicants for support.

18. Our work on this project is due to be completed by 30 September 2010. We will keep the committee informed of further findings as they emerge.

**References**


November 2009

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26 As measured by the standard deviation of the cash value of support.
Annex 1

EXAMPLE OF INDIVIDUAL RISK UNDER DUAL AND UNITARY CARE/BENEFIT SYSTEMS

Consider a person in great need—who should therefore be judged entitled to both AA and to LA services—and who applies for both forms of support. Assume the relevant rates of support are the lower rate of AA (£43.15 per week in 2007–08) and 10 hours of LA home care, valued at £19.30 per hour (Curtis 2009, p. 38).

Under the current dual support system, this person will experience one of four possible outcomes, depending on the result of the two eligibility assessments: (i) no support at all (£0 per week); (ii) AA only (£43.15 per week); (iii) LA only (£193 per week); (iv) both AA and LA (£236.15 per week). There is evidence of a high rate of error in eligibility assessments.27 Suppose that, on average, 15% of LA assessments are wrong and that the proportion of incorrect AA adjudications is 15% if LA care is not received but only 5% if adjudicators know that LA care is received.28 Under these assumptions, the applicant has a 2.25% chance of getting nothing, a 12.75% chance of receiving £43.15, a 4.25% chance of receiving £193 and an 80.75% chance of getting the full £236.15. The average outcome over a large number of similar people, would be £204.40.

Now suppose that the system is replaced by a unitary system of LA home care with a single eligibility assessment, which has a 15% chance of an incorrect rejection of the claim. If the reform is to be budget-neutral29 it must offer this individual the prospect of care services to the value of £240.47. Then, the applicant has a 15% chance of receiving nothing and an 85% chance of receiving £240.47 (implying the same average amount of £204.40).

Table A1
SUMMARISES THE DEGREE OF INDIVIDUAL UNCERTAINTY INVOLVED IN THE TWO SYSTEMS:

<table>
<thead>
<tr>
<th></th>
<th>Dual system (AA + LA home care)</th>
<th>Unitary system (LA home care only)</th>
<th>Proportionate increase in risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of receiving no support</td>
<td>0.0225</td>
<td>0.15</td>
<td>567%</td>
</tr>
<tr>
<td>General uncertainty</td>
<td>71.2</td>
<td>85.9</td>
<td>20.5%</td>
</tr>
</tbody>
</table>

LAs are permitted to take account of AA/DLA when means-testing individuals for care services,30 which would have the effect of reducing the total value of support received when both assessments are positive. This would strengthen the argument for a dual system: it would make no difference to the risk of receiving no support and would reduce the level of general uncertainty under the dual system.

Memorandum by Carol and Douglas Batchelor (SC 53)

SOCIAL CARE—DISCRIMINATION AGAINST THE DISABLED

The Select Committee has received written evidence from organisations which appear to accept the general principle of discrimination against the disabled, both on the grounds of their age and their means.

There is in our view a fundamental difference between disabilities, whether before and or after reaching retirement age and the need for social care particularly for the aged and infirm towards the end of their lives.

Disability by its very nature reduces the quality of life throughout the period of disability; it reduces the ability to work normally and to earn well. Disability usually brings with it additional costs and restrictions to life and liberty. These restrictions apply to the disabled person and often to their family carers as well.

To date the state has to some extent recognised that the disabled have a right to a quality of life and that it is right to support the disabled person in making the choices they feel best meet their needs, through providing the Disability Living Allowance (DLA). That allowance is in recognition of a right for the disabled to a quality life and a degree of independence and it is not treated as a means tested care benefit.

The DLA is made up of two quite separate components, the Mobility allowance and the Care Allowance. At present both components are allocated according to assessed needs and with out regard to means.

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27 Note that the 1999 Social Security Select Committee reported a 29% error rate for DLA assessments (SSSC 1999, para. 17).
28 There is a question about receipt of care services on the AA application form, so this presumably strengthens the claim of need.
29 In other words, to have the same average cost for this type of individual as the previous dual system.
30 Although they are required to make allowance for the additional costs of disability.
The State discriminates against retired disabled people by means testing attendance allowances granted to disabled people over the age of 65. The State also discriminates against those who care for the disabled throughout their lives by treating care related payments as income and as a result taxes those who assist the state by caring for the disabled.

The disabled, because of their reduced capacity to earn tend to have lower savings and less wealth. The state then further discriminates against them by assessing their wealth and effectively discounting the level of disability related benefit to be paid, thereby further reducing their already low level of financial resource.

The carers for the disabled are also discriminated against in so far as their wealth is taken into account in determining any benefits that they may receive and by virtue of the fact that any such benefit will be treated as taxable income. This provides a powerful financial incentive not to care, surely the last thing the state should be doing.

The proposals set out in the Green Paper for Consultation do not clearly draw a distinction between the needs and rights of the disabled and the near end of life care needs of the elderly and infirm.

The proposals in the green paper make it quite clear that the Care component of the DLA may become means tested in retirement and that the right to a quality of life and independence for the disabled may cease when they reach retirement age and are simply treated as any other elderly and infirm person.

It is suggested that some clear principles need to be stated to ensure that the disabled and their carers are not discriminated against. We suggest that these principles which could be agreed by all parties could be:

1. That the disabled and their carers should not be discriminated against on the basis of their age or their disability.
2. That disability benefits and related payments to carers are paid in recognition of the extra costs of living with a disability.
3. That payments to the disabled and their carers should be designed to enable the disabled person to remain as independent of social care as possible for as long as possible.
4. That DLA payments to the disabled and to their carers which relate to disability should not be means tested.

There is a clear case for recognising that discrimination on the basis of disability is inappropriate. It would be particularly unfortunate if those least fortunate in life were to be taxed by the state on the basis of their means, and as a result effectively beggared by the state over time because of their disability.

We therefore request that the Members of the Select Committee record their agreement with the principles above and recommend that Disability benefits should not be arbitrarily limited by retirement age or effectively reduced in value by what would amount to a wealth tax on the disabled and their carers.

November 2009

Memorandum by COMPAS (SC 54)

SOCIAL CARE

INTRODUCTION

This evidence is submitted by researchers Dr. Alessio Cangiano, Dr. Isabel Shutes and Sarah Spencer, CBE, at the ESRC funded Centre on Migration, Policy and Society (COMPAS), University of Oxford. Sarah Spencer is also Chair of the Equality and Diversity Forum and is currently serving on the advisory group to the Government Equality Office (GEO). COMPAS is a research centre of excellence with expertise on migration and labour markets. It has conducted a series of research studies on care and migrant labour.

The evidence in this document is based on a study conducted between Spring 2007 and Spring 2009—funded by the Nuffield Foundation and the Atlantic Philanthropies—which investigated the current and future demand for migrant (foreign born) workers in the provision of older adult social care; the experiences of migrant care workers, of their employers and of older people in residential and home care settings; and the implications of these findings for social care and migration policies. The research included a survey of 557 social care providers (residential and nursing homes and home care agencies), 56 interviews with migrant care workers and five focus groups with older people (both current and prospective users).

EVIDENCE

1. Migrant care workers have remained largely invisible in debates on future social care provision. The recent Adult Social Care Workforce Strategy surprisingly makes no mention of their role. Nevertheless, in 2008 18% of all social care workers in the UK were foreign born (122,000). In London, the migrant share of the social care workforce is over 60%. The reliance on migrant care workers has been significantly growing in the last decade: foreign born care workers accounted for only 7% of the social care workforce in 2001. In older adult care, 28% of care workers recruited in 2007 across the UK were migrants.
2. The overriding reason for the recruitment of migrants given by providers of care for older people was the difficulty of finding UK-born workers—nearly 50% of employers reported a shortage. Recruitment difficulties were attributed by employers to low wages and poor working conditions in the sector and associated with low rates paid by local authorities subcontracting care provision. The median gross hourly pay for care workers in adult services (Dec 2008–Feb 2009) is £6.56, only slightly higher than the National Minimum Wage (set at £5.73 in October 2008).

3. Most migrant care workers are recruited from within the UK. Although no accurate breakdown by immigration status is available, our estimates suggest that the migrant care workforce comprises large numbers of people who have entered the UK via non labour related channels—as refugees, family members, students, working holiday makers, or on ancestral visas. Therefore, the policy debate on migrant workers in the care sector, by focusing only on EU nationals and non-EU workers recruited on senior care workers visas, is partly misplaced.

4. Since the start of the recession there has been some evidence that applications from UK-born applicants are increasing. However, employers have reported that they may not have the necessary skills and/or motivation for care work. Nor it can be assumed that in the future there will be a large supply of care workers from within the EU—inflows of Easter European migrants have already declined and many are leaving the UK.

5. This study found that the contribution by migrants to the quality of care in this sector is appreciated by employers and older people: 71% of employers agreed that migrants have a “good work ethic”, 82% that they are willing to work all shifts and 68% that migrants are more respectful towards older people. A majority of employers (62%) stated that the quality of care provided by their organisation had not changed as a result of employing migrants, and 31% thought that the quality of their services had improved.

6. The main challenges concerning the migrant social care workforce are:

   6.1 66% of employers reported the lack of English language proficiency as a possible challenge of employing migrant care workers. Nuances in the language used in relation to care, regional accents and customs of older people were reported as particularly challenging.

   6.2 41% of employers reported that migrant care workers were not always well accepted by older people; in some cases migrant workers referred to verbal harassment by older people and a refusal to be cared for by them. The study found that employers were often unsure how to manage such situations.

   6.3 Self-reported national wage data (from the Labour Force Survey) suggest that a significant proportion of all care workers (close to one in five) may be paid below the National Minimum Wage, with recent migrants most often in that position. However, other data sources collected from employers provide different estimates, making it difficult to assess the actual proportion of the care workforce paid below the statutory pay levels.

   6.4 Migrant care workers interviewed for this study reported discrimination and abuse of employment rights, in terms of pay, less favourable shifts, unpaid overtime, non-payment of tax and NI, distribution of less popular tasks, and treatment by co-workers. They also reported little access to information or advice on employment rights.

   6.5 Live-in care workers face particular challenges and have fewer employment rights. Those working directly for older people were particularly vulnerable in relation to time worked and pay. There can be a tension between the personalisation agenda, promoting user choice and control, and the responsibility not to discriminate in the appointment or treatment of the carer.

7. Current demand for migrant care workers raises concerns in the light of future demographic trends. In the UK there is currently one care worker in older adult care for every 15 older people, and the projected increase in the number of older people means that, other things being equal, the size of the direct care workforce in the sector will need to grow by 400,000 over the next 25 years if this ratio is to remain at the current level. If the current percentage of migrant care workers in the workforce remains constant, the stock of migrant care workers working with older people will need to increase by an average annual growth of 3,000 migrant care workers (2.5%) to 195,000 in 2030.

8. Future demand for migrants in the care sector will depend on whether the root causes of care worker shortages—low pay and the low status of care work—will be addressed.

RECOMMENDATIONS

1. With regard to the future funding of social care, efforts should be made to make care work more attractive to the local labour force on a long-term basis by improving pay, conditions, status and career paths. Such efforts should also be targeted at men.

2. The Government should retain the limited migration entry channel for senior care workers and monitor the need for a legal channel for lesser skilled migrant care workers if pay and conditions in the sector do not attract sufficient and suitable job applicants within the UK. The alternative, if employers cannot recruit legal migrants to maintain care services, could be an increase in migrants working without permission—as is already the case in other EU countries. The possible impact of changes made to other
immigration routes—eg for refugees, students, family members—on the supply of migrant care workers should also be taken into account when migration regulations are revised. Better coordination between migration and social care policies is needed.

3. Government and employers should ensure that migrant care workers have access to English language provision and adequate social care training, accommodating the hours and shifts involved in care work.

4. The Equality and Human Rights Commission needs to address the discrimination experienced by migrant care workers, including guidance for employers on handling the hostility of some older people and their families towards migrant care workers, particularly in the light of the personalisation of social care services.

5. There is a need to improve access to advice and guidance on employment rights for migrant care workers. Trade unions, professional associations, local authorities and migrant organisations all have a role to play.

6. With regard to the personalisation of social care services, the Care Quality Commission, and local authorities funding home care, should monitor the implications of the employment of migrant care workers by older people in their own homes; and ensure that older people and their families have advice and support in relation to their responsibilities as employers, which includes treating staff appropriately and avoiding discrimination.

7. The contribution which migrant care workers are making to the care of older people should be given greater public recognition in debates on the future of social care.

November 2009

MEMORANDUM BY THE MAP2030 RESEARCH GROUP (SC 55)

SOCIAL CARE

EXECUTIVE SUMMARY

— This memorandum covers the costs of long-term care and disability benefits for people aged 65 and over under a range of potential reforms to the funding system in England.

— Under the current system, public expenditure on long-term care and disability benefits for older people is projected to rise from £15.8 billion in 2007 to £37.6 billion in 2032, an increase of 225%.

— The public expenditure costs in 2007 of introducing a policy of free personal care, along the lines proposed by the Royal Commission on Long Term Care (1999), would be approximately £1,980 million more than the current system; of introducing free personal care for people living at home, proposed by the Prime Minister at the Labour Party Conference, would be approximately £660 million more than the current system; and of introducing a Partnership model along lines suggested by the Green Paper, assuming 33% of personal care costs are guaranteed (HMG 2009), would be approximately £470 million more than the current system.

— The Green Paper proposes that the new National Care Service could be funded by transferring some disability benefits into the social care system. If, under the Partnership model considered here, Attendance Allowance and Disability Living Allowance for older people were withdrawn, then public expenditure costs in 2007 would be approximately £4,140 million lower than under the current system.

— Average weekly financial gains to care home residents would be largest for free personal care (around £95 a week in 2007), but would be between £30 and £40 a week under partnership options.

— Average weekly gains for home care users would be some £20–£30 a week under free personal care. They would be just £1 to £2 a week under the partnership model or, if Attendance Allowance and Disability Allowance were withdrawn, home care users would lose around £40 a week on average.

— Gains from all the reform options examined are largest for care recipients in the highest fifth of the (age-specific) income distribution and smallest in the lowest fifth. Under the partnership model with Attendance Allowance and Disability Living Allowance withdrawn, losses are largest in the lowest income group.

— Our findings on the partnership model are dependent on the form of the means test which would remain for that part of care costs not met by the state, particularly if Attendance Allowance and Disability Allowance are withdrawn. We have assumed that those means tests would operate as now. If they were more generous, gains (losses) could be larger (smaller) and more targeted on those on lower incomes.
ACKNOWLEDGMENTS
The MAP2030 Research Group is funded (grant number RES-339-25-0002) under the New Dynamics of Ageing Programme, a cross-council research programme involving the Economic and Social Research Council (ESRC), the Medical Research Council (MRC), the Arts and Humanities Research Council (AHRC), the Biotechnology and Biological Sciences Research Council (BBSRC) and the Engineering and Physical Sciences Research Council (EPSRC).

The Family Resources Survey and General Household Survey are crown copyright and made available by the Office for National Statistics via the UK Data Archive.

All responsibility for the analysis and views expressed in this paper rests with the authors.

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PAYING FOR LONG-TERM CARE: POTENTIAL REFORMS TO FUNDING LONG-TERM CARE

1. This discussion paper has been prepared by the MAP2030 study team as a contribution to the House of Commons Health Select Committee Inquiry into Social Care. This inter-disciplinary team, covering a number of institutions, is investigating the needs and resources of older people to 2030. It should be noted at the outset that this report is independent of work commissioned from the PSSRU by the Department of Health, exploring the costs and benefits of funding options in the Government’s Green Paper Shaping the Future of Care Together (HMG 2009).

2. The present paper covers a range of potential reforms to the funding system for long-term care in England. It presents current and projected future public expenditure costs of long-term care for older people under the reform options and the implications of the options for the costs of care borne by individuals in different income groups. The reform options considered here include a version of “free” personal care which was a policy recommended by the Royal Commission on Long Term Care (1999), the version of “free” personal care proposed by the Prime Minister at the Labour Party Conference, and several versions of a Partnership model along lines suggested by the recent Green Paper on care and support (HMG 2009).

3. In light of concerns about the restricted coverage of the current system we compare expenditure under a selection of the reform options to expenditure under a potential expansion in care services for older people along the lines of the care packages recommended in the Wanless report on funding social care (Wanless 2006). Such an expansion could also come about as a result of the reforms themselves: by reducing the cost of care to individuals the reforms might generate an increase in demand for care. The reforms could drive up the fees that care homes charge to local authorities. The sensitivity of the reforms to such changes is therefore investigated. All estimates relate to England and are expressed in constant 2007 prices.

METHOD

4. The method is as used in an earlier study and is described in detail in Hancock et al (2007). The analyses were conducted using two linked models—the CARESIM microsimulation model and the Personal Social Services Research Unit (PSSRU) cell-based long-term care finance model. CARESIM simulates the incomes and assets of future cohorts of older people and their ability to contribute towards care home fees or the costs of home-based care, should such care be needed (Hancock et al. 2003). The PSSRU model makes projections of demand for long-term care and associated expenditure, under clearly specified assumptions (Wittenberg et al. 2006).

POLICY OPTIONS CONSIDERED

Funding Policy Options Considered

5. Free personal care: The policy of free personal care has been described and discussed in detail elsewhere (Royal Commission on Long-Term Care 1999, Wanless 2006). The Royal Commission report envisaged several ways of implementing free personal care, one of which was that, for residential care, there would be a personal care allowance, applied by all local authorities (Royal Commission on Long-Term Care 1999: 66 £6.39). This sum would be deducted from the charges made in individual care homes, leaving the balance representing living and housing costs. There would be means-testing of ability to pay for hotel costs, entitling people with little means to receive help with the charges for living and housing. An important feature of this approach is that the amount allowed for personal care is applicable in any care home. This

31 The modelling of all options considered here assumes continuation of existing eligibility criteria relating to disabled older people who receive informal care. Disabled older people with informal carers are currently treated as “less eligible” for publicly-funded support than those without (DH 2003). Some implications of this are discussed at the end.

32 In nursing homes there is now also a standard NHS contribution to the costs of nursing care.
“fixed care costs” version of free personal care is the one we model. The weekly personal care allowance was set at £248.70 in April 2007 and assumed to rise with general price inflation in future years. The cost of all need for personal care at home, as assessed by local authorities, is assumed to be met by the state under free personal care.

6. Free personal care for those with the highest needs living in the community: The Prime Minister announced the Government’s intention to introduce a policy of free personal care for older people with the highest needs living at home. We model the implications of this policy by assuming that the means-test for local authority support for home care would be abolished for older people with personal care needs currently receiving “high” or “very high” packages of care, as defined by our model. In practice this means that those people with personal care needs receiving packages of home care of five or more hours per week would no longer contribute to the costs of their care. The means test remains for people receiving fewer than five hours of personal care, for those without personal care needs and for older people living in care homes.

7. Options relating to a partnership model: The Green Paper proposes a partnership model in which everyone who qualifies for care and support on the basis of their care needs would be entitled to have a set proportion of their basic care and support costs met by the state. The proposal has a progressive element such that older people with fewer means will have more of their costs met by the state; and those with the fewest means will have all their care costs met by the state (HMG, 2009). Based on our interpretation of the Green Paper, we assume that all those who qualify for care are eligible to have one-third of their personal care costs met by the state.35 The Green paper is not specific on who would be eligible for more than a third of their care costs. We assume that those who under the current funding system are entitled to a state contribution of more than one-third of their care costs, continue to receive the same state contribution as under the current system.34

8. Partnership model with withdrawal of some disability benefits: The Green Paper also proposed that the new National Care Service could be funded by transferring monies from some elements of the benefits system into the social care system. It suggests that one option is to withdraw Attendance Allowance (AA) for new claimants and transfer the money into the social care system (HMG, 2009). AA is a non means-tested benefit for disabled older people aged 65 and over and is payable at one of two rates. We model a variant of the partnership scheme in which AA and Disability Living Allowance (DLA)35 are withdrawn. Since receipt of AA or the middle or higher rate of DLA determines eligibility for a Severe Disability Premium (SDP) in Pension Credit we assume that if AA and DLA were withdrawn, the SDP would also be withdrawn. Receipt of AA and DLA also determine eligibility for Carer’s Allowance for carers of people with impairment, and the Pension Credit Carer Premium, but our analysis does not cover these benefits. Modelling of the withdrawal of AA under the current system, carried out by Forder and Fernandez (2009) for the Department of Health, has allowed for some targeting, but this does not seem to be described in the Green Paper itself and has not been modelled here. The Green Paper also implies some transitional arrangements, whereby “people receiving any of the relevant benefits at the time of reform would continue to receive an equivalent level of support and protection under a new and better care and support system” (HMG 2009: 104). The modelling here does not take account of this phasing-in of the reforms.

9. Effects of rises in care home fees: In independent care homes, fees paid in respect of residents who are supported by the local authority are often lower than those paid by “self-funders”. The free personal care and partnership model options would increase the proportion of care home residents eligible for local authority support with their fees and it is implicitly assumed here that all those receiving local authority support with their fees under the reform options would be eligible for the lower local authority fee rates. There could therefore be pressure for local authorities to increase the fees they pay to care home owners in respect of local authority supported residents.36 Two possibilities are considered here. In the first, local authority rates are assumed to remain at their current levels. In this case, part of the costs of the change would implicitly fall to care home providers, which is probably unrealistic. If fees for local authority-funded residents do not rise, the reforms would yield reduced revenue for care home providers and some might go out of business. In the second possibility, local authority fees are assumed to rise such that provider income per resident remains at its 2007 level under the current funding system. The higher fee rates are assumed to apply to all supported residents and not just to those specifically benefitting from the reformed funding system. The state contribution to personal care is taken to be unchanged so that all of the fee rise relates to hotel costs and is subject to means-tested user charges under all options.

33 The Green Paper also indicates that there would be investment in prevention, such as investment in re-ablement and tele-care (HMG 2009: 51–2, 103). This has not been included in the modelling here.

34 Although the options suggested by the Green Paper, modelled here, relate to the partnership option, it should be noted that there are similarities between the comprehensive option and free personal care.

35 A similar benefit which can be received by people aged over 65 who started to receive it before reaching that age for over 65s

36 In Scotland, when a “fixed care costs” version of free personal care was introduced, private and voluntary care providers were reluctant to provide places for older people under “integrated” contracts, under which local authorities managed the contractual arrangements with care homes on behalf of older people receiving free personal care (Age Concern Scotland, 2003: 19–20). The underlying problem, that local authority fees are lower than self-funders’ fees, is addressed here by allowing for scenarios in which local authorities increase the fees they offer to care home owners.
Pattern of Care Policy Options Considered

10. **Wanless pattern of care**: A scenario describing an expansion of services for disabled older people is modelled along the lines of the “core business” scenario described in the King’s Fund Social Care Review, led by Sir Derek Wanless (Wanless 2006). In the Wanless Review, under this scenario all older people identified as having personal care needs receive services at levels which are deemed to be cost-effective. Cost-effective services are defined as those which cost less than £20,000 per person per year to produce an outcomes gain equivalent to one ADL37-adjusted life year and can be understood as a year of life fully ADL-compensated. In the scenario reported here we have expanded services so that the total numbers of older people receiving services match those reported in Wanless (2006).

11. This scenario addresses the criticism that there is large unmet need in the current system (CSCI 2008; HMG, 2009). It also demonstrates the sensitivity of the projections to changes in the eligibility criteria for care services, which is of central importance to the partnership model since the offer of public resources is available only to those who “qualify” for care and support services. Combined with the free personal care and partnership funding reforms this pattern of care can also give an indication of the public expenditure consequences of demand for care increasing in response to the reduced care costs that individuals would face under those reforms.

**“Base Case” Assumptions**

12. The PSSRU and CARESIM models produce projections on the basis of specific assumptions about future trends in the key drivers of demand for long-term care (Box 1). A base case projection takes account of expected changes in factors exogenous to long-term care policy, such as demographic trends and trends in housing tenure. It holds constant factors endogenous to long-term care policy, such as patterns of care and the funding system. The base case is used as a comparison when the assumptions of the model are varied in alternative scenarios.

**BOX 1**

**KEY ASSUMPTIONS OF THE BASE CASE**

- The number of people by age and gender changes in line with the Government Actuary’s Department 2006-based population projections for England.
- Marital status changes in line with GAD 2006-based marital status and cohabitation projections for England and Wales.
- Prevalence rates of disability by age and gender remain unchanged, as reported in the 2001–02 General Household Survey (GHS) for Great Britain.
- Home-ownership rates, as reported in the pooled 2003–04, 2004–05 and 2005–06 Family Resources Survey (FRS), change in line with projections produced by the CARESIM model.
- The proportions of older people receiving informal care, formal community care services, residential care services and disability benefits remain constant for each sub-group by age, disability and other needs-related characteristics.
- The funding system remains unchanged as the current system for England.
- Health and social care unit costs rise by 2% per year in real terms (but non-staff revenue costs remain constant in real terms). Real Gross Domestic Product rises in line with HM Treasury assumptions.
- The supply of formal care will adjust to match demand and demand will be no more constrained by supply in the future than in the base year.

**Public Expenditure under Current Funding System and Policy Options**

13. All results relating to public expenditure under the current funding system and policy options are shown in Tables 1 and 2 and Figure 1.

**Public Expenditure under Current Funding System**

14. Public expenditure on long-term care and disability benefits for people aged 65 and over is projected to rise, under base case assumptions, from £15.8 billion in 2007 to £37.6 billion in 2032, an increase of 225%. These figures relate to public expenditure on long-term health services and social services and to all disability benefits for older people in England. If Gross Domestic Product (GDP) rose in line with HM Treasury assumptions, public expenditure on long-term care and benefits would rise from 1.29% of GDP in 2007 to 2.05% in 2032. These projections are sensitive to varying the assumptions about future life expectancy, trends in disability rates and trends in real unit costs (Wittenberg et al. 2006). They relate to the funding system currently used in England.

**Public Expenditure Costs of Options**

37 ADL stands for Activities of Daily Living. Difficulties in or inability to perform ADLs is a common measure of the need for care.
15. Under free personal care (fixed care costs variant) around 100,000 privately-funded care homes residents and around 200,000 privately-funded users of home care would become eligible for public support. The additional net public expenditure cost, compared to continuation of the current funding system, would be around £1,980 million at 2007 prices comprising an additional cost of around £2,075 million to social services, offset by a saving of around £95 million in disability benefits. This saving occurs because publicly-funded care home residents cease to receive AA/DLA and under free personal care, all care home residents are publicly-funded. The additional net public expenditure cost would rise to around £3,750 million in 2027 and £4,890 million in 2032 at constant 2007 prices. Public expenditure on long-term care and disability benefits would rise from 1.46% of GDP in 2007 to 2.31% in 2032.

16. Under free personal care at home for people with high needs the additional net public expenditure cost would be around £660 million in 2007. The net additional cost would rise to around £1,380 million in 2027 and £1,770 million in 2032 at constant 2007 prices. Public expenditure on long-term care and disability benefits would rise from 1.35% of GDP in 2007 to 2.14% in 2032.

17. Under a Partnership model (with 33% of personal care costs guaranteed), the additional net public expenditure cost, above continuation of the current system, would be around £470 million in 2007, comprising a cost of around £570 million to social services offset by a saving of around £95 million in disability benefits. The net additional cost would rise to around £1,170 million in 2027 and £1,590 million in 2032 at constant 2007 prices. Public expenditure on long-term care and disability benefits would rise from 1.33% of GDP in 2007 to 2.13% in 2032.

18. If, under a Partnership model, disability benefits are withdrawn, net public expenditure cost would be around £14,140 million lower than under the current system in 2007. There would be additional costs of around £1,175 million to social services but this is offset by a reduction of £5,320 million in disability benefits. The net reduction in public expenditure would rise to around £6,040 million in 2027 and £6,480 million in 2032 at constant 2007 prices. Public expenditure on long-term care and disability benefits would be 0.95% of GDP in 2007, which is a lower figure than the current percentage (1.29%). This would rise to 1.69% in 2032, which again would be lower than the percentage in 2032 under the current system (2.05%).

Sensitivity Analysis: Care Home Fees

19. Under free personal care where care home fees for local authority-supported residents rise, the additional net public expenditure cost, above continuation of the current system, would be around £2,200 million at 2007 prices rising to around £4,220 million in 2027 and £5,510 million in 2032 at constant 2007 prices. Public expenditure on long-term care would rise from 1.47% of GDP in 2007 to 2.34% in 2032.

20. Under the Partnership model where care home fees rise, the additional net public expenditure would be around £710 million in 2007 rising to around £1,660 million in 2027 and £2,200 million in 2032 at constant 2007 prices. Public expenditure on long-term care would rise from 1.35% of GDP in 2007 to 2.17% in 2032.

21. If, under the Partnership model, disability benefits are withdrawn and LA fees rise, net public expenditure cost would be around £3,900 million lower in 2007. The reduction in public expenditure would be around £5,540 in 2027 and £5,820 million in 2032 at constant 2007 prices. Public expenditure on long-term care would rise from 0.97% of GDP in 2007 to 1.73% in 2032. These percentages are both lower than their respective equivalents under the current funding system.

Sensitivity Analysis: Wanless Packages of Care

22. This sensitivity analysis considers the net public expenditure cost of an expansion of care services for older people as per the care packages recommended in the Wanless report on the funding of social care. The additional net public expenditure cost, compared with continuation of current care packages, would be around £3,200 million at 2007 prices comprising a cost of around £2,550 million to social services, £200 million to the NHS and £485 million in disability benefits. The net cost would rise to around £8,110 million in 2027 and £10,140 million in 2032 at constant 2007 prices. Public expenditure on long-term care would rise from 1.56% of GDP in 2007 to 2.60% in 2032.

23. If free personal care was implemented alongside expanded packages of care, the additional net public expenditure cost would be around £5,640 million in 2007 rising to around £12,750 million in 2027 and £16,100 million in 2032 at constant 2007 prices. Public expenditure on long-term care would rise from 1.76% of GDP in 2007 to 2.92% in 2032.

38 The modelling looks at the effects if AA and DLA for people aged 65 and over were withdrawn in 2007 and therefore does not take into account transitional arrangements, which the Green Paper suggests would be introduced (see £7 above).

39 A reduction in net public expenditure costs is also shown in the impact assessment prepared by the Department of Health, which shows a reduction in public expenditure of £1.1 billion in 2024 under the partnership option with withdrawal of some disability benefits (DH 2009: 3). This is a smaller reduction than that shown here in 2027, but the precise reasons for the difference are difficult to ascertain because the DH has not yet published details of its modelling of the reform options.
24. If partnership was implemented alongside expanded packages of care, the additional net public expenditure cost would be around £3,610 million in 2007 rising to around £9,170 million in 2027 and £11,580 million in 2032 at constant 2007 prices. Public expenditure on long-term care would rise from 1.59% of GDP in 2007 to 2.27% in 2032.

Table 1
PUBLIC EXPENDITURE ON LONG-TERM CARE AND DISABILITY BENEFITS FOR PEOPLE AGED 65 AND OVER UNDER POTENTIAL REFORMS TO FUNDING LONG-TERM CARE, ENGLAND, 2007

<table>
<thead>
<tr>
<th>Public expenditure on long-term care and disability benefits for people aged 65+</th>
<th>Long-term care</th>
<th>Disability benefits for people aged 65+ *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base case—Current funding arrangement in England</td>
<td>£ million</td>
<td>£ million</td>
</tr>
<tr>
<td>Free personal care in all settings</td>
<td>15,810</td>
<td>6,765</td>
</tr>
<tr>
<td>Free personal care for high/very high domiciliary care users</td>
<td>17,790</td>
<td>8,840</td>
</tr>
<tr>
<td>Partnership with 33% guarantee</td>
<td>16,465</td>
<td>7,420</td>
</tr>
<tr>
<td>Partnership, AA/DLA (65+) discontinued</td>
<td>16,280</td>
<td>7,330</td>
</tr>
<tr>
<td>Free personal care + fee rise</td>
<td>18,010</td>
<td>9,060</td>
</tr>
<tr>
<td>Partnership + fee rise</td>
<td>16,515</td>
<td>7,565</td>
</tr>
<tr>
<td>Partnership, AA/DLA (65+) discontinued + fee rise</td>
<td>11,910</td>
<td>8,185</td>
</tr>
<tr>
<td>Wanless packages of care</td>
<td>19,015</td>
<td>9,295</td>
</tr>
<tr>
<td>Wanless packages of care + free personal care</td>
<td>21,455</td>
<td>11,855</td>
</tr>
<tr>
<td>Wanless + partnership</td>
<td>19,425</td>
<td>9,825</td>
</tr>
</tbody>
</table>

Source: Caresim and PSSRU Models
Note: *“Disability benefits for people aged 65 and over” refers to Attendance Allowance (AA) and Disability Living Allowance (DLA).

Table 2
PUBLIC EXPENDITURE ON LONG-TERM CARE AND DISABILITY BENEFITS FOR PEOPLE AGED 65 AND OVER UNDER POTENTIAL REFORMS TO FUNDING LONG-TERM CARE, ENGLAND, 2007 AND 2032 (£ MILLION, % GDP)

<table>
<thead>
<tr>
<th>Public Expenditure—in £ million (2007 prices)</th>
<th>Public expenditure % GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>2032*</td>
</tr>
<tr>
<td>Base case—Current funding arrangement</td>
<td>15,810</td>
</tr>
<tr>
<td>Free personal care</td>
<td>17,790</td>
</tr>
<tr>
<td>Free personal care for high/very high domiciliary care users</td>
<td>16,465</td>
</tr>
<tr>
<td>Partnership</td>
<td>16,280</td>
</tr>
<tr>
<td>Partnership, no AA/DLA</td>
<td>11,670</td>
</tr>
<tr>
<td>Free personal care + fee rise</td>
<td>18,010</td>
</tr>
<tr>
<td>Partnership + fee rise</td>
<td>16,517</td>
</tr>
<tr>
<td>Partnership, no AA/DLA + fee rise</td>
<td>11,910</td>
</tr>
<tr>
<td>Wanless</td>
<td>19,015</td>
</tr>
<tr>
<td>Wanless + free personal care</td>
<td>21,455</td>
</tr>
<tr>
<td>Wanless + partnership</td>
<td>19,425</td>
</tr>
</tbody>
</table>

Source: Caresim and PSSRU Models
Note: * Projections of public expenditure are under-estimates since they assume constant take-up rates of DLA by age and gender and do not allow for maturation of the DLA scheme.
Figure 1

PUBLIC EXPENDITURE ON LONG-TERM CARE AND DISABILITY BENEFITS (65+):
DIFFERENCE BETWEEN CURRENT SYSTEM AND REFORM OPTIONS, ENGLAND, 2007
(£ MILLION)

£ million

Source: Caresim and PSSRU Models

Notes: see notes to Tables 1 and 2

FINANCIAL GAINS AND LOSSES TO CARE HOME RESIDENTS AND HOME CARE USERS FROM THE REFORM OPTIONS

25. The average financial gains from reform options, in pounds per week (April 2007 prices), are shown in Table 3. Figures are given for people aged 65+ and aged 85+ in 2007, and aged 85+ in 2027. They are shown separately and in combination for care home residents and home care users. The gains are largest under free personal care for care home residents who would be on average about £95 a week better off in 2007 and £130 in 2027, or a little lower if care home fees rise. Gains to care home residents would be between £30 and £40 a week under the partnership options.

26. Under free personal care, gains are somewhat lower for home care users—some £20–£30 per week. They are a little higher under Wanless patterns of care. This is because these patterns of care assume that more people are cared for at home with more expensive packages of care than at present. A move from the current funding system to free personal care under these patterns of care is therefore more beneficial for home care users than under current patterns of care. Home care users gain only small sums from the partnership model when AA and DLA are retained. If AA and DLA are withdrawn they lose about £40 a week.

27. These losses need some explanation. Because there are variations in how local authorities charge for home care services, we have assumed a standard means test that embodies the principles set out in national guidance. We have also had to make assumptions about how the means tests would work if AA and DLA were withdrawn. For the current funding system we assume that all Local Authorities include AA and DLA in the income which is taken into account in assessing user contributions to home care. We also assume, to comply with national guidance, that they therefore disregard part of any AA/DLA that the recipient uses towards Disability Related Expenditure (DRE)\(^40\). Under current guidance, if LAs disregard AA/DLA into account in the means tests, they do not need to make any allowance for DRE. We have assumed that if AA/DLA were withdrawn, LAs would not make any allowance for DRE but would apply an otherwise similar means test to the proportion of care costs not met by the state (ie two-thirds). Thus although some users gain from the non means-tested 33% state contribution, the loss of AA/DLA (and in consequence the DRE disregard) more than outweighs this gain for most.

\(^{40}\) DRE can include eg higher transport, laundry and heating costs attributable to the person’s disability.
<table>
<thead>
<tr>
<th>Table 3</th>
<th>AVERAGE WEEKLY GAINS, CARE HOME RESIDENTS AND HOME CARE USERS, 2007 AND 2027</th>
<th>£S PW, APRIL 2007 PRICES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care home residents and home care users combined</td>
<td>Care home residents</td>
</tr>
<tr>
<td>Free personal care in all settings</td>
<td>65+</td>
<td>85+</td>
</tr>
<tr>
<td>Free personal care for high/very high needs home care users</td>
<td>47.00</td>
<td>56.30</td>
</tr>
<tr>
<td>Partnership model, 33% guarantee</td>
<td>12.90</td>
<td>13.20</td>
</tr>
<tr>
<td>Partnership model, AA/DLA (65+), discontinued</td>
<td>-16.10</td>
<td>-8.20</td>
</tr>
<tr>
<td>Free personal care + LA fee rise</td>
<td>43.80</td>
<td>52.10</td>
</tr>
<tr>
<td>Partnership + fee rise</td>
<td>10.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Partnership with AA/DLA (65+) discontinued + fee rise</td>
<td>-19.00</td>
<td>-11.90</td>
</tr>
<tr>
<td>Free personal care in all settings under Wanless patterns of care</td>
<td>44.60</td>
<td>54.60</td>
</tr>
<tr>
<td>Partnership under Wanless patterns of care</td>
<td>8.70</td>
<td>11.50</td>
</tr>
<tr>
<td>Partnership with AA/DLA (65+) discontinued under Wanless patterns of care</td>
<td>-18.90</td>
<td>-13.00</td>
</tr>
</tbody>
</table>

Source: CARESIM model
**How do Financial Gains and Losses Vary by Income Group?**

28. To assess how the financial effects of the reform options for care recipients are likely to vary across different income groups, the average gains within each fifth (quintile) of the income distribution are compared. Care recipients are classified according to the quintile of the income distribution in which their income falls, where that distribution is specific to five-year age group. In the analysis that follows, someone classified as having an income in the highest income quintile has a high income relative to people of a similar age. This may not be a high income relative to the total population. When compared to the total population income distribution, older people are in general concentrated in the second and third quintiles of the income distribution, and this is even more pronounced for those aged 85 and over.

29. Financial gains and losses are measured by changes in users’ disposable incomes after meeting care costs. The distribution of these gains and losses are shown for care recipients aged 85 and over, in figures 2 (2007) and 3 (2027).

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41 Income is the net income (before housing costs) of the family unit (single older person or older couple) that they would receive when living in their own homes without any care needs. The before housing costs definition is not identical to that used in the annual National Statistics publication "Households Below Average Income". Here we do not include Housing Benefit (HB) as income on the grounds that high HB is at least in part the result of high rent so that to include it in income, without deducting rent, may exaggerate the economic well-being of people with high rents. Income is adjusted for family size using the OECD equivalence scale of 1 for the first adult, 0.5 for each subsequent person aged at least 14 years and 0.3 for each child aged under 14.

42 There may also be changes in users’ wealth if capital is depleted at different rates under the different options. This is not taken into account explicitly.
Figure 3

Distribution of weekly gains, £s pw: care home residents and home care users aged 85+, 2027

Source: CARESIM model

30. Under all the options, gains are highest and losses smallest in the top income group; gains are smallest and losses largest in the lowest income group. In 2007 care recipients (aged 85+) in the top income group gain around £90 a week from free personal care, some £20 a week from the partnership options and lose a maximum of £8 a week under the partnership models when AA/DLA is withdrawn. Care recipients in the lowest income group gain £20–£25 a week from free personal care, between £3 and £9 a week from partnership options which retain AA/DLA and lose up to £26 a week on average, when AA/DLA is withdrawn.

31. The picture in 2027 is similar to that in 2007, except that the extent to which the highest income group gain compared with a continuation of the current funding system is more marked, and differences in gains/losses across the lowest three income groups are less pronounced.

32. The distributional results take no account of how the revenue to finance the reform options might be raised, yet these may affect the results. In past work, we have examined the effect of financing free personal care by an increase in the higher rate of income tax and found that gains from free personal care would in fact be redistributive (Hancock et al. 2007: 79). Under the partnership options where AA and DLA for those aged 65 and over is withdrawn, we have not shown the effect for people who are not receiving care services who would also lose their AA or DLA.

33. There are of course many different ways in which revenue could be raised to finance extra public spending on long-term care and they will differ in their distributional effects. Analysis of a range of revenue raising options is planned for the future as part of MAP2030.

Discussion of Findings

34. A key finding is that current public expenditure would be lower by approximately £4 billion if disability benefits for older people were discontinued, even if a partnership model was introduced. The Green Paper does not contain much detail about its proposals and the modelling here has therefore relied on an interpretation of its intentions. For example, the Green Paper proposes to improve preventative services, such as re-ablement and tele-care, but these were not included in the modelling here because there is no indication of the extent of increases in spending on these services that might be implied. Nevertheless, if we had included these non-personal care costs, public expenditure costs would have been higher. Public expenditure costs would also have been higher in the initial period after the introduction of the reforms, had allowance been made here for some phasing-in of the changes. Finally, the detailed implementation of any withdrawal of disability benefits for older people, such as a targeting of the withdrawal, would also affect public expenditure costs and distributional effects.

35. However, there are also reasons why a discontinuation of disability benefits would reduce public long-term care expenditure under a partnership model. One reason is that disabled older people use disability benefits to pay for other disability-related expenditure, such as extra heating and special diets. A second reason is that disability benefits are a universal entitlement and all disabled older people, including those with informal carers, receive them. However, the Partnership model would not necessarily be universal in
this sense. The Green Paper seems ambiguous on this point. Following some statements in the Green Paper (HMG 2009: 103–104), it has been assumed here that there would be a continuation of existing eligibility criteria, under which disabled older people with informal carers (including some of the most severely disabled in the community) are regarded as “less eligible” for publicly-funded long-term care than those without informal carers (Royal Commission on Long Term Care 1999, FACs 2003, CSCI 2008). Elsewhere, the Green Paper seems to suggest that the new National Care Service might include disabled older people with informal carers (HMG 2009: 119). If the modelling were to assume a genuinely universal entitlement to publicly-funded social care by all disabled people, public expenditure on long-term care would be greater and more of the public expenditure saved from withdrawing AA/DLA would be transferred to social care funding.

36. Our modelling highlights the importance of the (as yet unspecified) details of how, under the Partnership Model, the means tests for the part of the care costs not met automatically by the state would operate, particularly if AA/DLA are withdrawn. If for example, LAs were required to disregard DRE even with AA/DLA withdrawn, home care users would lose less or even gain under this scenario. Likewise, if the means test applied to the two-thirds of care costs for care home residents were more generous than at present, the proposals would benefit those on lower incomes more than our results suggest.

REFERENCES

Age Concern Scotland (2003) Free for All? Age Concern Scotland’s Report into Free Personal and Nursing Care, Age Concern Scotland.


November 2009

Memorandum by the Anchor Trust (SC 56)

SOCIAL CARE

INTRODUCTION

0.1 Anchor Trust welcomes the opportunity to submit evidence to the Health Select Committee Inquiry into Social Care.

0.2 Our submission includes the views of staff representatives as well as feedback from our customers, the older people to whom we provide services.

BACKGROUND—ANCHOR TRUST

0.3 Anchor Trust is a not-for-profit organisation with more than 40 years’ experience of helping older people. We are England’s largest not-for-profit provider of sheltered housing for rent as well as England’s largest not-for-profit care home provider.
0.4 We provide great places to buy or rent as well as care and support services, including:

— Almost 700 retirement housing schemes.
— Property management services for leaseholders at 230 estates.
— 96 care homes, including two specialist dementia homes.
— Care to 3,000 customers in their own homes.
— Almost 1,000 integrated care and housing properties.
— Home improvements for more than 40,000 customers a year.

0.5 We are increasingly integrating the range of services we provide into people’s homes and have developed Anchor At Home, which provides home care with additional support to enable people to stay in their homes, such as gardening, shopping and handyman services.

EXECUTIVE SUMMARY:

0.6 We welcome the positive moves by all the major political parties to address the question of future funding of long-term residential and domiciliary care for older people. The select committee inquiry is further welcome evidence of a growing recognition of the challenges presented by our ageing population and a desire to respond to these issues.

0.7 However, we have significant concerns that solutions proposed thus far by both the Government and Opposition parties are not of the scale necessary to meet the needs of older people, the fastest-growing segment of our population. This is particularly true given the increased strain being placed on public finances as a result of the economic downturn.

0.8 As the number of people aged 85 and over grows faster than any other age group in the UK, it is time that these issues were debated honestly and openly.

0.9 Consideration of future funding of long-term residential and domiciliary care should start with a commitment to services which prevent the need for more expensive and intensive high-impact services. This saves public money and improves quality of life.

0.10 We support efforts to increasingly put older people in control of their care and support as part of the personalisation agenda. But the personalisation debate should be about how to ensure we provide care which is tailored to the individual. Increasingly, the word “personalisation” has simply focused on enabling older people to manage the financial aspects of their care.

0.11 Providing choice is laudable. But personal budgets for older people raise significant risks. Not least of these are concerns about how vulnerable adults can be safeguarded in such an environment and that total funding for social care services can be more easily eroded under such a regime. It is also not clear that all older people will want or be able to manage budgets directly.

0.12 The social care workforce needs to be recognised for the skills they already have. Further training and development will continue to be needed as longevity and associated care needs increase. Such continuous development means staff will be better able to provide services which are tailored to individuals’ specific needs. We believe the Government should create recognised career pathways for social care professionals.

FUNDING OF LONG-TERM RESIDENTIAL AND DOMICiliary CARE FOR OLDER PEOPLE

1.1 The starting point when considering future funding of long-term residential and domiciliary care should be a commitment to services which prevent the need for more expensive and intensive high-impact services.

1.2 The assurances in the social care funding Green Paper were therefore welcome. However, we have real concerns that hard-pressed local authorities may not be able to deliver on this commitment when having to make difficult funding decisions. We would welcome a ringfencing of such funding streams.

1.3 The risk that local authorities may feel unable to focus resources on preventative services was highlighted by the Communities and Local Government Select Committee’s report on Supporting People, published on 3 November 2009. The committee warns that “vulnerable people must not lose out as local authorities and their partners grapple with tightening budgets and the challenges of delivering services in a multi-agency environment.”

1.4 To develop preventative services would mean a shifting of resources to keep people well. Fair access to care is in place but Local Authorities interpret the rules in their own way within their locality. The system and criteria need to be tightened up so that the same principles are applied across the country, resulting in preventative services being valued for what they can achieve given early intervention.
1.5 We welcome the Green Paper’s proposals for a needs assessment which is the same across England. This is a major step forward and would mean older people can take the results of that assessment wherever they go, enabling them to live the life they choose, wherever they choose.

1.6 The only way portable assessments will happen in practice is for a resource allocation system to be put in place for all client groups based on need and not diagnosis.

1.7 The present variations between local authority practices are inefficient and do not appear to add value at a local level. A national framework should be developed to calculate local funding allocations and ensure they are in proportion to the local cost of care, which can vary significantly across the country.

1.8 Such consistency of approach will reduce the workload for local authorities, slashing bureaucracy and unnecessary public sector administrative costs.

1.9 However, a fully national funding regime would not take into account local market factors such as staff remuneration and travel costs etc. Furthermore, funding at a national level would mean a total overhaul of local government finance. We prefer a part local/part national approach, which offers consistency and portability. Realistically, this would create a central role for the local authority, which is best-placed to understand the local cost of care.

1.10 Too often, decisions on care at a local authority level are made on the basis of price. The price paid should reflect the need for social care to have a higher status and become increasingly professionalised. We would recommend the use of a national “fair price for care” model, such as that developed by the Joseph Rowntree Foundation to ensure a consistent and fair approach across the country.

1.11 We support the proposal made by the English Community Care Association for vouchers to be provided, based on assessments, with which individuals could shop around to find the right combination of services for themselves. We believe such vouchers should only be redeemable through a registered care provider, in order to ensure services are regulated appropriately.

1.12 We believe that the housing elements of long term care (ie the cost of board and lodging) should be covered for those on low incomes. Housing benefit should be payable for those who do not have the means to pay for the housing element of care home services.

1.13 The concept of a National Care Service is something to be welcomed. We would have liked to have seen a NCS funded in the same way as the NHS; with both care and health needs being met and free at the point of delivery. This would negate the situation of having to decide when to provide free health care to those being deemed as sick and those deemed merely as frail or disabled having to contribute to their care.

1.14 However, a fully tax-funded solution has been discounted in the Government’s Green Paper consultation as placing too heavy a burden on the working population. We believe that, of the three options for funding put forward in the paper, the comprehensive option has many merits but is unlikely to be popular as the compulsory nature of the contributions makes it appear too similar to taxation.

1.15 Our preference therefore is for a partnership approach.

1.16 The NCS should have a crucial role in educating people about the cost of care, their likely entitlement to State support and the options for self-funding. Insurance and equity release options will be key mechanisms for self-funding and the NCS and wider government should promote these options.

1.17 A suggested way forward is that a care duty could be made of people’s estates and the level of payment would reflect their wealth. There is already a mechanism for collection on people’s estates over a certain threshold sum and this could be further utilised to collect payments towards a National Care Service.

**PERSONALISATION OF SOCIAL CARE SERVICES**

2.1 The personalisation agenda is one we support; both in terms of shaping services around the needs of individual customers and giving them control over choosing and paying for those services. We already provide personalised services in our homes and domiciliary care. But the personalisation debate should be about how to ensure we provide care which is tailored to the individual. Increasingly, the word “personalisation” has simply focused on enabling older people to manage the financial aspects of their care.

2.2 The drive to put social care funds into the hands of older people themselves, rather than pay for services via local authority commissioners, means all care providers will have to transform their business models. Anchor is changing from a commissioner-led organisation to one which is increasingly focused on meeting the needs of thousands of individual customers.

2.3 As a large, national organisation we are able to respond quickly to the changing market and re-engineer the business. But moving to personal budgets too rapidly means smaller organisations will struggle to survive.

2.4 Commissioners will also need to change very significantly.
2.5 We propose a transition phase to enable providers and commissioners to adjust to the new environment.

2.6 We have concerns that vulnerable groups, such as those with dementia, may not be able to manage their own budgets. There are also concerns that regulation of all providers will be impossible if individuals can spend government subsidy however they wish.

2.7 We do not believe personal budgets will slash the expensive bureaucracy currently associated with administering funding. We also have concerns that personal budgets could undermine the integrated nature of extra-care provision, if it were to separate funding for the housing and care elements.

2.8 Any government pursuing the personalisation agenda must do so in a way which protects vulnerable people.

2.9 This could include exemptions for certain groups as well as vetting to ensure third parties, such as friends or relatives, are well positioned to make decisions on the individual’s behalf.

MORE EFFECTIVE, CONSISTENT AND USER-FRIENDLY SOCIAL CARE SERVICES.

3.1 Our “person-centred” approach to care aims to reduce the need for medication by shaping services to customers around their specific needs, interests and way of life.

3.2 Just 12% of residents in Anchor care homes are receiving antipsychotic drugs compared with a sector average of 20% across the UK. The lower use of drugs in Anchor homes is due to a range of relevant, unique and engaging non-pharmaceutical approaches.

3.3 A cure for dementia is some years away and the focus until a cure is found should be on high-quality care, which recognises the needs and aspirations of individuals.

3.4 Care workers need increasingly specialist skills to respond to customers’ increasingly complex needs. For example, at Anchor we now have 500 dignity champions, who have received specialist advanced training in dementia care.

3.5 The people who provide this specialist care should be recognised as professionals and rewarded appropriately.

3.6 Politicians can do much to tackle unemployment by promoting social care as a career of choice. We welcome the subsidy for social care providers who provide employment and training to out-of-work young people. Links with welfare to work providers should also be encouraged and supported with appropriate funding.

3.7 There has to be recognition that there is a cost associated with good quality care. This is particularly the case given the advent of individual budgets and the move away from large volume council-wide contracts.

3.8 Public subsidy should focus on outcomes and enable providers to pay social care professionals substantially more than the minimum wage.

December 2009

Memorandum by Circle Anglia (SC 57)

SOCIAL CARE

1. FUTURE FUNDING OF LONG TERM RESIDENTIAL AND DOMICILIARY CARE

It is difficult to comment on any of the funding options proposed in the Shaping the Future of Care Together Green Paper without being able to look at the detail of each scheme at the full cost implications for individuals. The key issue for providers however is less the type of system chosen, and more the amount of additional money any option would bring into the sector to address shortfalls. There are however, a number of comments we would like to make with regard to the general principals of some of the options.

— Insurance—Voluntary or compulsory insurance schemes are not a good option for people with long-term mental and physical health conditions. Many have already lived on a low income for many years and would struggle to pay this type of contribution. This could lead to a two-tier system of care where the most vulnerable are left even more exposed that they are at the present time.

— Partnership—Although it is suggested that the Government fund one third to one quarter of a person’s care bill, as fees vary the percentage will have to be set at a national average. In this case, it is likely that the contributions made by the Government will simply replace non-means tested benefits such as Attendance Allowance.
With regard to the funding of Residential Care, there has been and remains a clear distinction between the costs of bed and board and the costs of help with washing, dressing and so on. The former will need to be paid for by the individual. For those entering Residential Care, the costs of accommodation can be as high as those for care. This means that as little as half the total bill for someone moving into Residential Care would be covered.

In terms of Domiciliary Care, we cautiously welcome Gordon Brown’s announcement that free personal care would be available to people in England from next year although this seems to be targeted towards those with the highest care needs. Again, it is unclear where the funding for this is from, but presumably Local Authorities will have to manage this within the resources given to them. We are concerned that if Local Authorities face a large bill for free home care, this might result in cuts in other social care funding and a focus on providing services to people with critical needs only, creating a two-tier system.

Finally, an area which we would like to see addressed in the debate on future funding of care is what is actually defined as “care”. Does the definition cover services such as occupational therapy, physiotherapy, pharmacists and activities? Presumably these would be excluded from the cost of care, in which case, if people want to go beyond basic care and support, they would have to pay for this themselves. This could mean that the costs of care are still not being met.

2. THE PERSONALISATION OF SOCIAL CARE SERVICES

Whilst we welcome the principle of personalisation and as an organisation have already embraced the approach through our person-centred approach to support and care planning, we do have a number of concerns:

— It is likely that individual purchasers will have different priorities to commissioners and are more likely to value consistency and friendly staff above training and good quality monitoring systems. This will be reflected in the prices that they are prepared to pay. This may result in the driving down of costs of often specialist support down to domiciliary care levels.

— We would also welcome some clarity regarding the fit between personalisation and accommodation-based services. Some providers are responding to this challenge by developing core service offerings which are tied to the conditions of the tenancy. We are concerned that new and existing accommodation-based services are unsustainable due to the fragmentisation of the market, which can be a threat to the viability and also put economies of scale at risk. This lack of clarity will also affect the future development of Supported Housing developments as the unavailability of revenue funding for these schemes will make them a risk for investment.

— Issues around safeguarding also remain a concern. There has been no extension of the registration scheme for workers who directly provide care and support to individual purchasers. Whilst organisations which provide care and support are subject to both registration and inspection, staff employed directly by an individual will escape both. This raises the question of whether enough is being done to safeguard individuals purchasing care for themselves. We know that the committee is looking at this issue and would support and encourage this work.

3. EFFECTIVE, CONSISTENT AND USER FRIENDLY SUPPORT CARE SERVICES

There needs to be a stronger focus on information, advice, help and guidance services. We already know that there is a lack of clear information about social care services. Brokerage or advice and guidance roles need to be set up to help people identify the changes they want in their lives, to fund not only support services but to identify opportunities within the community and negotiate with providers. These services need to be linked to local communities in order to have the kind of relationship with providers which service users will benefit from.

As we enter an era of cuts in public spending and benefit freezes, many service users, including those with Direct Payments, will have less money. This means that more time needs to be spent supporting people with money management problems and debts, alongside time spent supporting people to negotiate their way around new systems and processes. Direct Payments or Individual Budgets will mean an increasingly central role for the individual, which will result in a growing role for families and friends who will also need support.

Anne Anketell
Managing Director
EPIC Trust part of the Circle Anglia group

November 2009
Memorandum by the Resolution Foundation (SC 58)

FUTURE OF SOCIAL CARE SERVICES

The Resolution Foundation is an independent research and policy organisation. Our goal is to improve the well-being of low earners by delivering change in areas where this income group is currently disadvantaged. We do this by:

— undertaking research and economic analysis to understand the challenges facing low earners;
— developing practical and effective policy proposals; and
— engaging with policy makers and stakeholders to influence decision-making and bring about change.

SUMMARY

This memorandum focuses on our response to the publication of the Green Paper and draws specific attention to the three areas of concern for the committee in the corresponding three sections:

1. Overview (including personalisation).
2. Reform of the system—critique of Green Paper proposals to deliver a more effective, consistent and user-friendly social care services.
3. The future funding of social care for older people.

The Foundation welcomed the broad thrust of the Green Paper. We believe the shift towards seeing care as a universal entitlement rather than a safety net will vastly improve the experience of many low earners who often find themselves squeezed by the current system. Low earners are on the “cliff-edge” of means testing eligibility: the majority are not eligible for free or subsidised state care, and yet their low incomes make care costs a significant financial burden. This group are likely to spend a larger proportion of their weekly budgets on care than both higher and lower earners. In other words, low earners are squeezed by virtue of the mixed economy that characterises the funding and delivery of social care.

— 78% of low earners over the age of 65 own their home outright, and so are likely to have assets which will make them ineligible for state-funded social care.
— 45% of low earners have made no provision to pay for their care, and 68% of low earners feel that care is becoming less affordable.
— Some of tomorrow’s low earning older people are today’s carers: low earners are 25% more likely than average to be providing some form of informal care.

We believe that further clarification of the terms of the “universal entitlement” is needed before a lasting funding settlement can be agreed. From the perspective of low earners, further detail is needed on the funding options before they can be assessed against fairness and affordability criteria. It is also unlikely that any single funding model proposed in the Green Paper will provide the full solution to increased demand for social care. Rather, the Government needs to consider a range of options and a staged approach.

We also argue that more work is now needed on planning the route to reform. This will require greater alignment between funding options and a reformed delivery model, as well as a more explicit focus on what a successful reform process might look like. It will also require momentum to be maintained on the immediate reform agenda as we continue to work towards a long-term settlement. In particular, enabling the market for social care to work effectively is vital to improving outcomes for older people, and for delivering a vision of choice and personalisation.

We therefore welcome the Health Select Committee’s inquiry and we believe further work is required before a lasting settlement for long-term care can be achieved.

SECTION 1: OVERVIEW—THE REFORM OF SOCIAL CARE

1. We welcomed the publication of the Green Paper but fear it will not generate the breakthrough in social care reform that many were hoping for. In our view this will not be achieved unless greater attention is paid to two overarching issues, as well as getting the detail right: first, greater clarity about what we mean by a “universal offer” in social care, and what aspects of the current mixed economy of care services should be available for free and to whom; and second, the route to reform itself. It is only through focusing on these issues that the questions asked in the Green Paper about funding can be fully addressed.

2. With regards to the issue of personalisation, the Resolution Foundation welcomes the steps to give older people more freedom over their care budgets. However, many low earners who are income poor and asset rich will not qualify for an individual budget under the current arrangements as they are only available to those who qualify for state assistance. Many low earners are already self-funders, and yet struggle to personalise services, due to the very real challenges in accessing their equity and managing their finances, and the difficulties in understanding what choices they have in the first place.
Social care: a mixed market for a social good

3. At its highest level, long-term care functions as a mixed market, with defined demand for care (based on need) and formal supply (residential and domiciliary care). Care is also a social good, which the government has a duty to provide for those in need if they cannot afford it themselves.

4. We have reproduced a diagram of the mixed market of social care that we developed for our report A–Z: mapping long term care markets. It illustrates some important points that should inform debates about the funding and the reform of social care:

5. It is essential that any debates about funding social care start with a consideration of how the current system looks from the perspective of its users. We are particularly interested in how it looks from the perspective of low earners. Our research shows that it is seen as:

- Complex system—while low earners understand in broad terms the difference between social care and health, they are confused about the terms of means and needs-testing, variations in eligibility, and this leads to a sense that they have to fight to get their needs met, and that the current system creates barriers to people accessing services to which they are entitled.
- Unfair system—low earners feel the current system penalises those people who have worked hard and planned for their old age.
  "What the government does is make us poor before they help"
- Expensive system—low earners are on the cliff edge of eligibility: nearly three quarters of them have too many assets to qualify for state support (usually in the form of housing), and yet their relatively low incomes makes paying for their costs a significant financial burden.

6. Our view is that the Green Paper has not sufficiently clarified the roles and expectations of the state, families and individuals in relation to care. Over the years, social care has been defined and redefined and many of the more recent government publications, including the Green Paper, talk about state-provided care and support as a universal offer or a citizenship entitlement, rather than as a more limited safety net. At this juncture, it remains unclear what forms of support, and what level of care (if any) form part of any settlement covered by the funding options set out in the Green Paper.

Section 2: Reform of the System

7. In this section we reiterate the key principles we believe should underpin the changes proposed in the Green Paper.

Clear national framework

8. The Green Paper’s commitment to a new national minimum entitlement will end the current confusion experienced by low earners. It should alleviate their concerns about the “unfairness” of the current system, which are borne out of a lack of clarity regarding entitlements and responsibilities of the individual and the family. However getting this entitlement right, and making it transparent, is crucial.

44 For more in-depth analysis please see Resolution Foundation, Navigating the Way: the future care and wellbeing of older people (December 2008)
9. We agree that needs eligibility should be set at a national level (i.e. the equivalent of critical, substantial, moderate or low). However local councils should still have the flexibility to set their own monetary values for different levels of eligibility (increasingly in a transparent way thanks to personal budgets) to reflect the costs of labour and other local variations that may need to be taken into consideration.

10. The level at which needs eligibility is set is as important as who sets it. We believe this is fundamentally a political decision that should reflect the government’s ambitions for how older people and society are treated in the future, the priority given to preventative care, and the available resources for care funding as weighed up against other priorities.

11. We have argued that a minimum entitlement of care should be made available to both older people and their carers. We believe it should be part of a clear national framework for care, which would also include:
   - A national regulatory framework.
   - Clear delegation of key functions to appropriate agents.
   - Greater clarity in the respective roles of individuals, families and the state.
   - A national set of eligibility criteria for state contributions.\(^45\)

**National assessment**

12. We welcome the commitment to a national, portable assessment of needs, which we believe will help low earners predict whether they will have to contribute to their care costs and prepare accordingly.

13. We believe that a care and wellbeing assessment should be part of any national minimum entitlement for everyone over 65 and their carers. It should be divorced from questions about eligibility for state funding, thus tackling problems with the current system that often conflates people’s needs with their means. This conflation means those people deemed ineligible from a financial perspective do not have access to a needs assessment (many self-funding low earners): a CSCI study found that nearly half of self-funders surveyed did not have such an assessment.\(^46\)

**Market shaping role**

14. Our view is that the local authority role should not only be to address market failure but also to proactively shape local markets for care. They need to build their capacity to provide strategic oversight of local care markets. And they need to work behind the scenes to facilitate and encourage this market, help providers to respond to consumer feedback, and to offer flexible, affordable and good quality services.

15. Previous work by the Resolution Foundation identified the tools that a market shaping organisation would require to ensure sufficient volume, diversity, quality and affordability of supply\(^47\).

16. Market shaping should be focused on building healthy demand, healthy supply and stronger feedback loops between the two. It should also find ways of encouraging innovation in response to this feedback\(^48\).

**Care navigation service\(^49\)**

17. Historically, the majority of local councils do not believe they have a role in providing information and advice to self-funders and others whose income or assets put them beyond eligibility for state-provided care.\(^50\) All of this is compounded by the fact that often people do not plan for their care, so only start to find out about their options at the point of crisis—for example when they are under pressure to vacate a hospital bed. In addition, often low earners get lost in the system, too rich to qualify for state-funded support, but finding the burden of their care costs extremely high.

18. Therefore, central to meeting people’s needs is a service which integrates a range of support (information, advice, advocacy) on a range of issues (health, care, housing, finance and entitlements) to help people navigate the care system. This should form the “first stop shop”: a single, integrated source of information and advice, as the Green Paper proposes.

19. A great deal of further work is required to map the care journeys of self-funders, whose routes in and around the care system are often more complex and opaque than those people whose care is provided and paid for by the state. Their need for advice is not only at the first point at which they need some kind of care, but also further down the line, for example when their assets are dwindling thus making them potentially eligible for state support.

20. We believe such a unified service should be delivered via the appropriate range and mix of channels. Ultimately it should be a national system, but combined with a network of local “first stop shops” commissioned by the local authority.

\(^45\) For more in depth analysis please see *Navigating the Way*, ibid.


\(^47\) Resolution Foundation, *Local Market Shaping* discussion paper (December 2008)

\(^48\) Resolution Foundation, *Innovation and Efficiency in Long Term Care* discussion paper (December 2008)

\(^49\) For more in depth analysis please see *Navigating the Way*, ibid.

SECTION 3: FUNDING

21. Our view is that further work is needed to clarify the terms of the “universal entitlement” before a lasting funding settlement can be agreed. From the perspective of low earners, further detail is needed on the funding options before they can be assessed against fairness and affordability criteria. It is also unlikely that any single funding model proposed in the Green Paper will provide the full solution to increased demand for social care.

22. The Government must consider:

— How to secure additional collective funds for care and support, through innovation, efficiency, redirecting funds from other activities and reforming the tax and national insurance systems.

— How to stimulate a market that will incentivise greater contributions directly by individuals. We believe that this will require a mixed market solution of both state-sponsored and privately provided products. This diversity is necessary to meet individuals’ needs, resources, attitudes to risk and inclinations to plan, and to ensure people are also able to cover accommodation costs and low level care needs.

— How to plan a reform process that takes a staged approach to a funding settlement, where new approaches are introduced over time to meet the needs of different generations at different life stages.

Affordability of paying for care

23. Despite their low incomes, over three quarters of low earners are likely to be deemed ineligible for state support (usually thanks to their housing assets), and we believe that the current limits on eligibility—particularly the capital limit of £23,000—are set very low. Part of the debate following the Green Paper must be about whether as a society we wish to extend these limits, particularly given some evidence that unmet need, measured in hours per week, peaks for quintiles 3 and 4.

Enhancing individual contributions to the future funding of social care

Equity release

24. Equity release products could be particularly relevant for the current older generation. However currently the product remains unpopular with low earners—they do not trust it following the negative press around “sale and rent back” schemes. State support for equity release could help the private market to develop, as well as improving trust in the product. Government could encourage the development of equity release products—and potentially supply them directly—for those who only need relatively small amounts of equity to pay for domiciliary care or preventative measures such as home modifications.

Long-term care insurance

25. Pre-funded (as opposed to immediate need) long-term care insurance schemes pool risk across society and therefore have associated welfare benefits. However, as with equity release schemes, there are currently market failures in existing insurance models that need addressing.

26. For low earners specifically two further issues arise. First, current long-term care insurance products are out of reach simply because the premiums are too expensive to pay for. And second, our analysis indicates that low earners are generally less likely than higher earners to take up insurance products.

27. A state-sponsored model will generate higher levels of trust and increase the range of options for developing products that meet the needs of low earners. But there is no reason that the functions of an insurance scheme could not be delivered via the private sector either. However, the government would need to take action to tackle the issue of low trust in this solution. It would also need to play a role in terms of ensuring that people had access to appropriate and affordable financial advice, and if the insurance scheme was compulsory, there are obvious regulatory implications for the state.

Long-term savings products

28. Among the post-baby boomer generation it is not clear what asset holding will look like in coming decades. It is quite possible that higher levels of personal debt among younger cohorts coupled with delayed access to the housing market will have a significant impact on the housing wealth enjoyed by future generations. Therefore identifying and supporting alternative asset-building vehicles is an essential part of helping people to plan for their old age.

29. While awareness of privately-provided products such as ISAs and pensions is widespread, it remains the case that many people enter retirement with inadequate savings. The government is already moving to tackle this issue through improving personal pension provision, including the introduction of auto-enrolment and personal accounts. Specific and progressive tax incentives at the point of saving coupled with soft compulsion could help to encourage further saving for old age among younger cohorts.

51 See presentation by Jose-Luis Fernandez at King’s Fund, August 2009
30. The Green Paper is at risk of posing a false choice between funding options. Rather, the debate must focus on how to achieve a staged approach towards a sustainable system that engages working-age adults in planning, saving and insuring for their care through a variety of mechanisms. The policy intention must be to increase collective and individual contributions to the costs of care simultaneously. This will require a range of approaches.

31. **Conclusion**

The process of reforming social care still has a long way to go. We urge the government to work closely with stakeholders to clarify outstanding questions, and to design an approach that communicates the necessary ambition and urgency to all concerned.

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**Annex A**

LOW EARNERS AND THE LONG-TERM CARE SYSTEM

32. We have been working to improve outcomes for low earners in the long-term care system since 2008. To inform this work we conducted a series of focus groups and some polling in collaboration with Deloitte in early 2008, and ran a number of workshops in autumn 2008. We have recently updated this work through a series of in-depth interviews with low earners who are self-funding their own care. We have attached summaries of these interviews at Annex A, and all of the research described here informs this response. We have published our findings in a range of reports and discussion papers all of which can be found on our website. These include:

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- *Lost: low earners and the elderly care market* (February 2008)
- *Navigating the Way: the future care and wellbeing of older people* (December 2008)
- *Innovation and Efficiency in Long-Term Care* (December 2008)
- *Local Market Shaping* (December 2008)
- *Facilitating Increases in Long Term Care Funding* (December 2008)
- *Home Equity: accumulation and decumulation through the life cycle* (forthcoming, 2009)
- *Funding Future Care Need: the role of councils in supporting individuals to access the capital in their homes* (forthcoming, 2009)

33. Our analysis shows that:

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- There are 4.9 million retired low earners across the UK and they are two times more likely than the UK average to be care users.
- 78% of low earners over the age of 65 own their home outright, and so are likely to have assets which will make them ineligible for state-funded social care.
- 45% of low earners have made no provision to pay for their care, and 68% of low earners feel that care is becoming less affordable.
- Some of tomorrow’s low earning older people are today’s carers: low earners are 25% more likely than average to be providing some form of informal care.

34. In this context, long-term care presents particular challenges for low earners. They are on the “cliff-edge” of means testing eligibility: the majority are not eligible for free or subsidised state care, and yet their low incomes make care costs a significant financial burden. This group are likely to spend a larger proportion of their weekly budgets on care than both higher and lower earners. In other words, low earners are squeezed by virtue of the mixed economy that characterises the funding and delivery of social care.

35. Our polling work with low earners in the care system shows that this group does not have a positive view of the system as it currently stands. 75% of low earners believe that social care should be seen to be as important as the National Health Service—but at the moment they perceive that the system is unfair, punishing those who work and save to prepare for old age:

> “I'm beginning to think we were very foolish to have struggled and bought our own house…you don’t get any help from anybody. And people who have wasted their money, they get everything given to them”

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52 Resolution Foundation, *Closer to Crisis? How low earners are coping in the recession* (November 2009)
54 Lost, ibid.
55 Lost, ibid.
36. They believe that care is declining in quality and becoming less affordable. These perceptions come from their “squeezed” position: too rich to qualify for state-funded care, and too poor to have the resources to invest in commercial products designed to help people plan and pay for their care.

37. In addition, low earners report that they struggle to navigate the system and understand what they are entitled to, or what choices they have. Qualitative research conducted by the Resolution Foundation highlighted how people felt they had to “do all the chasing” in order to get information and “fight” to access services. These perceived hurdles are seen by low earners as a means to ration services and are considered unfair in this light.

38. That said, our research provides some important insights about low earner attitudes towards how care is paid for. Low earners have a strong sense of fairness and in this context they accept the concept of means testing. However the inclusion of the family home as part of the means test is seen by low earners to penalise those who have sought to look after themselves and live independently of state support throughout their lives.

“If I pay half, the government pays half, as long as I’ve got enough funds.”

“I think we should perhaps be asked to pay a reasonable cost, but not this exorbitant charge… 50/50 would be ideal.”

39. When it comes to paying for social care, low earners accept the need to individuals to make some kind of contribution. As a group they are generally supportive of funding models that are about “giving something back”. Our polling showed that three quarters of low earners (compared to 71% on average) would pay an extra penny in the pound on income tax to raise funding and quality. And just under half (48%) support the idea of compulsory contributory schemes so that individuals and government pay for care together.

“I think its unfair that we have to pay so much income tax on our state pension when we have a small private pension […] I think we are taxed far too heavily on our pensions, if they would ease on that, we could help ourselves with our care.”

40. Perhaps unsurprisingly given their increased likelihood to be doing some kind of informal care, low earners believe government should be doing more to support carers, either through direct financial support or through respite care. Low earners see carers as saving the government money by reducing people’s reliance on formal care and on residential services.

41. Finally low earners in our research emphasised the importance of consistency in what is funded where—between different parts of the country and even within single local authorities.

January 2010

Memorandum by the Dementia Services Development Centre (SC 60)

THE FUTURE OF SOCIAL CARE SERVICES

1. Executive summary. Of the 700,000 people with dementia, over 60% live in the community. Others are mainly cared for in local authority or private care homes. It is possible to transform the personalisation of care services for these people, and to create more effective, consistent and user friendly services for them and their carers using existing resources and knowledge. However, there is an impediment which means that resources are used to recreate materials and techniques that already exist, costing time and money that society can ill afford. Providers claim they can’t afford to provide education or change without significant investment. The government should consider calling in the knowledge and expertise of the existing UK experts in dementia services improvement before accepting this. Even if better funded services do better than poorly funded ones, the difference may not be in proportion to the extra funding. We suggest four high impact areas.

2. The Dementia Services Development Centre (DSDC)\(^{56}\) which was originally based at the University of Stirling and now has opened bases in London (2009) and Belfast (2007). The aim of the DSDC is to improve services for people with dementia and their carers. It does this through research, teaching, information provision and change management. It works with health and social care services, in the private, public and third sector. The DSDC works across the UK, and has been funded by the health departments in Northern Ireland and Scotland, in addition to substantial charitable donations, to create and deliver education and change management tools in dementia care. Over 21 years the DSDC has assisted in the creation of dementia centres in other parts of the world, most recently in the Netherlands.

\(^{56}\) www.dementia.stir.ac.uk
3. As a not for profit organisation undertaking initiatives supported by public and charitable funding, we were concerned that the objectives outlined in the National Dementia Strategy are not being met. These observations were supported by the findings of the January 2009 report of the National Audit Office. Our frustration is heightened by the fact that we have delivered solutions to many of the obstacles to implementation in other places. We offer four examples:

(a) Research shows that when you have dementia, having a carer at home offers a 20 fold protection against institutionalisation. Carers rely on home care staff and social services to support their task of caring. Home care providers say because they cannot retain staff, they cannot afford to train them. Research shows that if you train staff, retention improves. DSDC provides low cost, easy to deliver education packages. The cost of these programmes is minimal compared with the cost of replacing a staff member because much of the material was created from the public purse. Commissioners should require providers to have all staff pass the basic multiple choice Homecare Practice License test, as a bare minimum standard.

(b) Social workers (as well as health care workers) are not trained in how to provide support immediately after diagnosis. Research indicates that support is extremely important. DSDC offers a research based distance learning online programme over ten weeks (at the level of an undergraduate course, so easily completed by anyone who already has a diploma qualification or degree) on early interventions. The course was originally commissioned by NHS Education for Scotland, but is relevant to workers in any part of the UK and beyond. Comments from the two cohorts of 40 students who were given free places in Scotland indicate that from their point of view this is the most practical and useful education they have ever had for helping people after dementia diagnosis.

(c) The quality of care and the culture in care homes is frequently criticised. DSDC have developed and delivered a low cost programme which has shown that it changes the culture of care. The skills from the programme are embedded in the senior staff of the care home as they take groups of their own care workers through a six month programme. The cost for the six months programme including all materials and assessments is around £130 per person currently, and care homes are taking second and third cohorts through the programme.

(d) There is 20 years of research that shows the design of premises can make a huge difference to the dependence of people with dementia. Scotland has required that all new primary care premises are dementia friendly. Making care homes and health care premises dementia friendly can reduce the cost of care, and reduce adverse incidents. In England currently, architects and designers are commissioned for care homes and day centre developments with no requirement for research based dementia design principles. DSDC has a design certification scheme, and a scheme to educate social care staff to audit their own buildings, and an inexpensive course for architects. Most of the interest comes from the private sector, where they know it makes financial sense to do it properly. Even a makeover can save money that can then be used for other services. Many changes are cheap and quick—as simple as increasing the wattage of particular light bulbs, for example.

4. When we try to explain these to commissioners and practitioners in the public sector, we are often met with suspicion and treated as if our aim is merely to “sell” training. Rather, we are sharing good practice, and we operate from within the public sector.

5. Our recommendations are as follows:

(a) All home care staff who have been in post for over three months should be assessed using the fifty question multiple choice Home Care Practice Licence assessment to ensure minimum standards of care for vulnerable people at home, and this should be a requirement laid down by local authority commissioners of home care.

(b) Every social work or community nursing team must have at least one team member qualified in post diagnostic support and early interventions for dementia.

(c) All care homes must provide evidence of systematic staff training other than fire safety, moving and handling and food handling such as the Best Practice programme.

(d) All care homes and primary care premises should be audited for “dementia friendliness”, for example through training local social services staff in the use of the Design Audit Tool, to create a list of research based improvements. Dementia design knowledge must be required of architects who are commissioned in the public sector.

We are confident that significant change can come even from these first four recommendations.

Professor June Andrews MA, RMN, RGN
Director
January 2010
INTRODUCTION

1. This submission is a response to a request from the Select Committee on the specific issue of evidence of “Age discrimination” within Social Care, and, what actions the EHRC is taking or proposing.

2. The Equality and Human Rights Commission (the Commission) is an independent advocate for equality, human rights and good relations in Britain set up by an Act of Parliament. The Commission aims to reduce inequality, eliminate discrimination, strengthen good relations between people, and promote and protect human rights.

3. The Commission welcomes the opportunity to respond to the Select Committee on this important issue.

4. We are pleased that the Government’s lead on age has placed the UK well ahead of other European states. Particularly, the Department of Health’s (DH) efforts to support the implementation of the provisions in the Equality Bill relating to ending age discrimination and promoting age equality in the health and adult social care system.

5. In response, the Commission provided a comprehensive submission to the Review of Age Discrimination in Health and Social Care which was carried out by Sir Ian Carruthers and Jan Ormondroyd. As a follow up to the review’s recommendations, we will provide the DH shortly with our views on their strategy on preparing the NHS and social care in England for the age requirements. As part of this consultation, we have supported the DH with a series of regional stakeholder events focused on refining their strategy. More broadly, we have responded to the GEO on their consultation relating to the general provisions on age discrimination within the forthcoming Equality Bill. We have also submitted an extensive response to DH on the Adult Social Care Green Paper “Shaping the Future of Care Together”. We will be pleased to submit copies of the above responses to the Select Committee if requested.

AGE DISCRIMINATION ISSUES WITHIN SOCIAL CARE

6. The findings from the Review of Age Discrimination in Health and Social Care provided a comprehensive overview of the evidence on ageism and age discrimination in social care. Of particular note is the literature review by the Centre for Policy on Ageing. This study looked at all aspects of the potential for ageism and age discrimination in adult social care including institutional and individual ageism and age discrimination; quality and level of services; direct and indirect discrimination; differential levels of funding; attitudes of professional staff; and evidence reflected in the attitudes and views of service users. We have also referred to the following instances of age discrimination in social care in our own responses:

— Age-based discriminatory practices appear embedded in our existing system of social care. For example, progress in extending Direct Payments to older people has been slow. If they are not to be left out of this development, adequate support, advocacy and advice for those who wish to take it up are paramount.

— Quality of life factors which are used in assessments for state-funded support for adults of working age, and issues relating to recovery for people with mental health problems, do not appear to be generally implemented for older adults.

— Earned income is excluded from calculations regarding charging for services, but pensions are included.

— Cost-ceilings for older people are significantly lower than for younger users of social care, which has placed the needs of older people as low priority when compared to younger users.

— With an ageing population with many now encountering impairments at later ages, they face a double impact of age discrimination; For example the Disability Living Allowance (DLA) is a non-means-tested benefit for disabled people with care or mobility needs. People who claim DLA before their 65th birthday can continue to receive it after the age of 65. However people whose disability arises at or after the age of 65 (or who don’t claim help until after 65) can only claim the much more limited Attendance Allowance (AA). The following example from a voluntary sector agency in response to our consultation for the From Safety Net to Springboard report illustrates the impact of such practice:

“... When he turned 65, the local authority reduced his individual budget, stating that the approved hourly rate for over 65s was lower. What was he supposed to do? Sack his Personal Assistants and recruit cheaper PAs to do exactly the same work?”

— There is also recent evidence of age linked discrimination where this aligns alongside other forms of prejudice in an increasingly diverse adult community. Some older LGB residential service users have apparently felt themselves forced to resume closeted sexuality due to the homophobic cultures within residential services. This is directly related to age discrimination and is likely to increase.
7. Our main emphasis however in both our responses and in this submission seeks to avoid restating the comprehensive work, done by Sir Ian Carruthers and Jan Ormondroyd. Instead they reflect our aims now to add to the steps being taken to overcome age discrimination wherever it arises.

**OUR RESPONSE TO AGE DISCRIMINATION**

8. Overall, the Commission looks forward to continuing our current work with the Department of Health and others towards securing greater equality for people of all ages and ensuring smooth and effective implementation of the Equality Bill in both Health and Social Care sectors. In this domain the DH has shown a leadership, commitment and openness for the kind of national policy and practice development that we have consistently sought from it in other areas. We are currently in dialogue with the Department to identify what further steps they need to take to enable them to deliver this.

9. The Commission is also about to sign a formal Memorandum of Understanding with the Care Quality Commission to embed all aspects of human rights and equality into service inspection across both Health and Social Care. We also hope to approach the Council for Health Regulatory Excellence who have oversight of professional body regulators, to agree some similar but perhaps less formal accord. This may prove vital to reach those areas of social care where service inspection cannot alone reach issues of staff custom and practice; in this case via the General Social Care Council. A similar less formal arrangement has already been agreed with Monitor, the governance regulator of Foundation Trusts, albeit this may be less relevant to Social Care providers. This approach demonstrates pro active measures that will allow us to start influencing for greater age equality long before the envisaged Equality Bill age provisions become law.

10. At the immediate time, and in order to start addressing identified age discrimination, EHRC staff will engage with the DH efforts to develop appropriate resource for staff across the Health and Social Care sectors.

11. The EHRC itself has already commenced an extensive programme of production and dissemination programme for the Equality Bill once it becomes law. These will include both statutory and non statutory guidance for employers, service providers and service users in the Health and Social Care sector across all strands and including age.

12. Finally, and arguably of similarly high potential impact, the EHRC is now seeking to embed human rights within Social care and other vital public services. The Commissions’ Human Rights Inquiry and lately its Human Rights Strategy have identified the over location of GB human rights with the most emotive and controversial issues. The importance however of a human rights based approach in Health and Social Care as drivers for service excellence is now also becoming clearer, and the Commission is working towards the bi partisan aspiration for public service quality improvement.

13. A human rights based approach can additionally help to mitigate some technical issues that arise when the sole recourse is to equality laws. For example, age discrimination in Social Care affects older service users who also probably have rights within disability equality law but often do not self identify as disabled. Some younger disabled people are meanwhile arguably over identified as disabled rather than as teenagers or young adults. In each case the value of a human rights based approach can over arch and supplement the protections from either age or disability equality law to these groups, because of its universal application.

14. The Commission is already supporting initiatives by the DH and British Institute of Human Rights to have a “human rights based approach” within health trusts. In order to complement these steps the EHRC is now also collaborating within the National Cancer Strategy and with Macmillan Cancer Support to identify how such an approach can “travel” with the service user, right across both health and social care services, rather than just lodging in singular services. This “pathway” approach to human rights has much potential to follow either the patient or service user where ever they receive “Care”.

15. In particular it may have potential benefit for many older people facing age or other discrimination within Social Care. For example, one simple example of a form of ageist practice that pervades both health but more so social care is the gradual degradation of older peoples’ names. The simple act of checking and re checking a preferred name can help to ensure that cordiality in social care does not become disrespectful and eventually even partially abusive. Over familiar use of abbreviated first names and attaching prefixes such as “our” and “old” is an enfeebling form of conditioning for service users who unsurprisingly respond with lowered self esteem once in such environments. A much simpler awareness of human rights which defines how “respect and dignity” can be simple measurable behaviours that work for both staff and service users are we believe some of the ways to address the ageist attitudes and practices that still arise in too many social care settings.

*February 2010*
Supplementary note to a written question by the Department of Health (SC 01B)

Q. Re social care, we gather it’s been recommended to the Government several times that better data on healthy life expectancy be obtained, given the shortcomings of the standard data set on this, which is derived from the General Household Survey.

Most recently, the House of Lords Science and Technology Committee recommended in 2005 that ONS be funded to do a longitudinal study on disability-free life expectancy. Apparently the Committee received a response from the DWP (presumably because of the pensions angle to this issue) that it would “look to progress” this recommendation.

Is the DH able to let us know whether anything has happened as a result of this, please?

A. Since 2005, the Government has commissioned several pieces of research which will provide better data with which to estimate disability free life expectancy:

1. DWP and the Office of Disability Issues (ODI) have commissioned the ONS to implement a major new longitudinal study of disability issues in Britain, known as the Life Opportunities Survey (LOS).

   The LOS will track the experiences of disabled people over time to assess transitions through key life stages. Survey topics will include work and learning, health, transport, community and social life, leisure, use of key services, caring and domestic life, hate crime and discrimination, income and benefits.

   Non-disabled people are also taking part in the survey. This means that the life-opportunities of disabled and non-disabled people can be compared. This will allow the changes to life opportunities that occur with the onset of impairment to be better understood.

   Fieldwork began in June 2009, with a first report on interim result expected to be published later this year. More details can be found on the ONS website at: www.statistics.gov.uk/about/methodology_by_theme/life-opp-survey.asp.

2) A consortium of UK Govt Departments (including DH and ONS) and the US National Institute of Ageing fund the English Longitudinal Survey of Ageing (ELSA) which can be used to estimate healthy life expectancy from the age of 50 upwards.

3. The ONS continues to produce estimates of healthy life expectancy at birth and at age 65: the latter are used to monitor progress on PSA18.3 (joint DWP/DH PSA indicator).

   The ONS will be publishing period-based estimates of disability free life expectancy at birth and at age 65 by registrar general’s social class and spearhead breakdown in England, 2001–03 using the Longitudinal Study in February’s edition of Health Statistics Quarterly.

4. ONS and ODI are leading on a project to deliver harmonised questions on the subject of disability for use in the Integrated Household Survey’s core module, which will have the data strength to enable sub-national estimates of healthy and disability-free life expectancy intercensally, in addition to supporting the data needs of national legislation: for example the Disability Discrimination Act and Single Equality Act.

5. The Medical Research Council (MRC) is funding a repeat of the Cognitive Function and Ageing Study (CFAS), which will also yield data that could be used to estimate healthy life expectancy at age 65.

February 2010