House of Commons
Health Committee

Social Care

Fourteenth Report of Session 2010–12

Volume 2

Volume II: Oral and written evidence

Additional written evidence is contained in Volume III, available on the Committee website at www.parliament.uk/healthcom

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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.

Membership

Rt Hon Stephen Dorrell MP (Conservative, Charnwood) (Chair)
Rosie Cooper MP (Labour, West Lancashire)
Andrew George MP (Liberal Democrat, St Ives)
Barbara Keeley MP (Labour, Worsley and Eccles South)
Grahame M. Morris MP (Labour, Easington)
Dr Daniel Poulter MP (Conservative, Central Suffolk and North Ipswich)
Mr Virendra Sharma MP (Labour, Ealing Southall)
Chris Skidmore MP (Conservative, Kingswood)
David Tredinnick MP (Conservative, Bosworth)
Valerie Vaz MP (Labour, Walsall South)
Dr Sarah Wollaston MP (Conservative, Totnes)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

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.

The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

Committee staff

The staff of the Committee are David Lloyd (Clerk), Sara Howe (Second Clerk), David Turner (Committee Specialist), Steve Clarke (Committee Specialist), Frances Allingham (Senior Committee Assistant), and Ronnie Jefferson (Committee Assistant).

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1 Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).
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Julie Jones CBE, Chief Executive, Social Care Institute for Excellence, Martin Knapp, Director, Personal Social Services Research Unit, London School of Economics, Professor Gillian Manthorpe, Director, Social Care Workforce Research Unit, King’s College, London, and Richard Humphries, Senior Fellow, the King’s Fund.

Heléna Herklots, Services Director, Age UK, Jeremy Hughes, Chief Executive, Alzheimer’s Society and Bruce Moore, Chief Executive, Hanover Housing.

Tuesday 8 November 2011

Jo Webber, Deputy Policy Director, NHS Confederation, Peter Hay, President of the Association of Directors of Adult Social Services (ADASS) and Strategic Director Adults and Communities, Birmingham City Council, and Councillor David Rogers OBE, Local Government Association (LGA).

Mark Lobban, Director of Strategic Commissioning, Families and Social Care, Kent County Council, Helen Buckingham, Director of Whole System Commissioning and Deputy Chief Executive, NHS Kent and Medway, Sheila Bremner, Chief Executive, North Essex NHS PCT Cluster, and Jenny Owen CBE, Deputy Chief Executive & Executive Director for Adult Social Services, Essex County Council.

Tuesday 22 November 2011

Frances Patterson QC, Commissioner for Public Law, Richard Percival, Team Manager of the Public Law Team, and Tim Spencer-Lane, Lawyer, Public Law Team, Law Commission.

James Lloyd, Director, Strategic Society Centre, Chris Horlick, Managing Director of Care, Partnership Assurance, Nick Starling, Director of General Insurance and Health, Association of British Insurers, and Andrea Rozario, Director General, SHIP Equity Release.

Tuesday 6 December 2011

Andrew Dilnot CBE, Chair, Dame Jo Williams DBE, Commissioner, and the Rt Hon Lord Warner, Commissioner, The Commission on Funding of Care and Support.

Tuesday 10 January 2012

Liz Fenton, Chief Executive, Princess Royal Trust for Carers, and Emily Holzhausen, Director of Policy and Public Affairs, Carers UK

Dr James Mumford, Senior Researcher, Centre for Social Justice, and David Orr, Chief Executive, National Housing Federation

Tuesday 17 January 2012

Paul Burstow MP, Minister of State for Care Services, and David Behan CBE, Director General of Social Care, Local Government and Care Partnerships, Department of Health.
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Oral evidence

Taken before the Health Committee
on Tuesday 25 October 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Barbara Keeley
Grahame M Morris
Dr Daniel Poulter
David Tredinnick
Valerie Váz

Examination of Witnesses

Witnesses: Julie Jones CBE, Chief Executive, Social Care Institute for Excellence, Martin Knapp, Director, Personal Social Services Research Unit, London School of Economics, Professor Gillian Manthorpe, Director, Social Care Workforce Research Unit, King’s College, London, and Richard Humphries, Senior Fellow, the King’s Fund, gave evidence.

Q1 Chair: Good morning. Thank you for coming. This is our first public evidence session in an inquiry into the future shape of social care, so you come at a good time to influence the Committee’s thinking at an early stage. Perhaps I could begin by asking you briefly to introduce yourselves and tell us where you are coming from.

Professor Manthorpe: Good morning, everyone. I am Gill Manthorpe from the Social Care Workforce Research Unit at King’s College, London, which is a Department of Health policy research unit. I am also associate director of the NIHR School for Social Care Research.

Julie Jones: I am Julie Jones, the Chief Executive of SCIE, the Social Care Institute for Excellence. Our job is around knowledge transfer, trying to find out what works well and getting it out to practice as fast as we can. We are a practice organisation, not a policy organisation.

Martin Knapp: Good morning. I am Martin Knapp. I am Director of the Personal Social Services Research Unit at the LSE and I am also a director of the School for Social Care Research.

Richard Humphries: Good morning. I am Richard Humphries, Senior Fellow in social care at the King’s Fund.

Q2 Chair: Thank you very much. Could I open the questioning by focusing on Dilnot and where you feel we are, following the Dilnot report in the summer? One of the recommendations of Dilnot was that if the Government took certain steps the effect would be to unlock a new source of revenue for social care through private funding—private insurance. How confident is each of you that, if the Dilnot recommendations were adopted, there would be a new market which would grow up and unlock a further source of funds for this sector? That seems to me pretty fundamental as a starting point to this discussion. Who would like to start?

Richard Humphries: They are all looking at me, Chair, so I will kick off. We have been sceptical for some time about the exact contribution private insurance could bring to this, and for all sorts of reasons. No country I am aware of relies, to any significant extent, on private insurers to generate income for social care. Even if the capped model proposed by Dilnot were implemented, many people with relatively modest assets, or even those who are quite well off, would probably opt to take the risk rather than an insurance policy. It is generally a thumbs down, I think.

I wonder if we are barking up the wrong tree little in terms of how financial products can help with this. We all know—there has been an elephant in the room about this debate, although not in this particular room—about the enormous housing wealth of people over 60, but by no means all older people, which has to be brought into the equation of how we fund the increased quantity and quality of social care we will need in the future. It is about the sort of products which will enable people to draw down on that wealth to help with their care and support costs rather than insurance per se. Housing-based models and equity release probably have more mileage here than straightforward insurance products. That is a long answer to a short question. I am not encouraged, particularly.

Martin Knapp: I would add that there is a terrible myopia about social care needs. People do not recognise the risk that they, themselves, will have face of needing to use long-term care services in the future.

I also agree with Richard about the equity release model. To me, it feels like the more attractive and viable approach. It has not been any more successful in getting off the ground than long-term care insurance until recently, but I understand there are some experiments under way, and perhaps we can learn from those.

Julie Jones: Dilnot represents an opportunity to move this into its next phase, even if it is not yet the entire...
answer, because we do not have public confidence, at the moment, in the social care system. We certainly do not have a good understanding of what social care offers, how it is funded and what implications there are for families, for all the reasons that Martin has mentioned. The Dilnot report gives us the best analysis we have had, probably, for a very long time. There is a risk of giving it the thumbs down and saying, “No. It has to go into the long grass,” but that would be a very poor outcome. The baby boomer generation—of which I am proudly one—has an enormous responsibility now. The generation behind us and the generation ahead of us are not sitting on the sort of assets that my generation represents and if we do not have that conversation about making sure we take more responsibility for our own care, it is a lost opportunity. Dilnot gives us the platform for those conversations.

Q3 Chair: In what sense does Dilnot provide a platform for a discussion about housing wealth?

Julie Jones: Specifically, what he does is open up an opportunity to talk about the options. He has come down to a particular set of proposals, but he also has some other proposals in there, such as raising the current entry point, which might be a welcome opening to a conversation about, “Yes, families and individuals will take more responsibility, but not if the system stays as it is.” So there are one or two proposals.

Q4 Chair: But if the discussion is just on the cut-off points, then the discussion between the generations, from the baby boomer to the people coming on behind, is, “Raise the thresholds and you pay more than we thought we were going to have to.”

Julie Jones: Yes. That is inevitable. These two gentlemen may well be right about the insurance model not giving us all the answers, but what Dilnot represents as a whole—and he did ask us to look at it in the round—is an opportunity not to stay stuck where we are. Stuck where we are is not a safe place for social care.

Q5 Barbara Keeley: I want to ask about two aspects. First, clearly, we know that people do not think about social care and, if they do, they want to put off the idea of funding it. I have seen surveys suggesting people would rather spend their money on today and the near future than investing or saving it for social care. We need to consider how we get the debate opening to a conversation about, “Yes, families and individuals will take more responsibility, but not if the system stays as it is.” So there are one or two proposals.

Q6 Dr Poulter: I want to pick up on the equity release point for a moment. You make a good point that the baby boomer generation has a lot of wealth and carries with it a lot of equity in property and other assets. However, there is an issue that, if we are putting in place any financial system to support adult social care, particularly dealing with the challenges of the elderly care spectrum, it needs to be a sustainable system that lasts the test of time. That is true of the current baby boomer generation but there are, as you alluded to, problems with the generation that is coming through that may not necessarily share those same assets and equities. Is that focus on equity release perhaps only, potentially, short-termism?

Richard Humphries: Possibly. However, if we look at the pattern of housing wealth over the next 20 or 30 years, it is not going to change that much, so we have a good window of opportunity. The key point is that this may need different solutions for different generations. The baby boomers will not have that housing wealth for ever, although they will de-cumulate some of it to people who inherit from them. We have to flex different approaches according to different circumstances. At the moment, we have the relatively unique opportunity of this massive housing wealth bubble sitting there. We cannot pile all the costs of care on to general taxation because the implication is that working-age people will be paying in taxes for the care of many people who will be considerably wealthier than they are. It is the point about intergenerational fairness in all of this. Could I make a general point about Dilnot in response to Barbara Keeley’s point?
Q7 Dr Poulter: I have one more follow-up on that, first. You contradicted yourself there. You were talking, at the end, about intergenerational fairness, but we have to have in place a sustainable system that is going to last. We do not want to be talking about this question again, if we do come up with a solution, in 15 or 20 years’ time. Often, the great tragedy in healthcare or social care policy is that we are always reinventing the wheel when we would like, in many respects, to have a sustainable system that is going to work. The concern you have alluded to is that the equity release system may only last for one generation, or a substantive period of time, but should we not be looking at a more sustainable solution for longer than that?

Richard Humphries: Yes. We have to look at a variety of funding methods, but the value of Dilnot is that he has set out a framework in which the costs can be shared between the individual and the state—whether those individual contributions come from insurance, housing wealth, pensions or whatever. That is the value of Dilnot and that is, potentially, the cornerstone of a new settlement. I do not hear anybody fundamentally disagreeing with that. There is no great intellectual battle of the giants going on there. It seems as if the Treasury or others worrying about this are merely going to get clobbered under the current system.

Q8 Barbara Keeley: You were going to come back to me.

Richard Humphries: That was the point. What Dilnot does is set out the framework as to how the costs, at the moment, are shared in a way that is terribly confused and confusing. It is totally iniquitous that people who have more than £23,250, but not that much more, get clobbered under the current system.

Q9 Barbara Keeley: To clarify, you do not think there is any way in which Dilnot should have gone further because, if this is to be a sustainable solution for 20 to 40 years, we are not going to be able to revisit it too many times.

Richard Humphries: I think he could have gone a lot further. There is a history of reports on this subject going back years and years to the Royal Commission 14 years ago. Many of them set out a great vision for the social care system of our dreams. Many of those reports never stood any chance of a realistic prospect of getting implemented. The judgment as to producing a report which does stand a realistic prospect of getting implemented is as much about what you leave out as what you put in. Dilnot could have said more, perhaps, about the underfunding of the current system. But he was not asked to determine the quantum of resources needed. He was asked to come up with a mechanism by which we pay for it and by which the costs are shared. That is the great achievement of the report.

Chair: We do not want to spend all morning on Dilnot, but Rosie and Andrew want to come in. Then, perhaps, we can move on to other subjects.

Q10 Rosie Cooper: You have led the Committee to the point I was going to discuss with you. The majority of people welcome Dilnot. It is an opportunity for this big discussion and one we may not see again for a substantial number of years. Yet, Dilnot is predicated on measuring that unmet need and knowing what unmet need is out there. Do you know how that is or can be measured? What do you think the Treasury’s reaction to that is? Will that not then take you right back to the position you described of a report that may never get implemented, because, at the core of it, is the huge amount of money needed to cover that unmet need?

Richard Humphries: How long is a piece of string? Lots of reports have researched unmet need. I wonder to what extent we would need to measure this in the degree of forensic detail that is being talked about. We know, for example, that 82% of local authorities will only respond to needs that are substantial or critical. We know that, over the last five years, the number of older people using publicly-funded social care services has gone down. It has gone down even though the older population has increased and the over 85s has gone up by nearly a quarter. We do not need to do any great research to tell us that there is a heck of a lot of unmet need out there. One of the fundamental questions for our society, which Dilnot was not asked to address, is: What kind of social care system do we want? What level of need do we think the state should respond to? What do we think carers should do? There is a whole debate about that which we probably have not had. Maybe the current engagement process the Department of Health has initiated will give us some answers to that. Colleagues may wish to contribute.

Martin Knapp: I would only add that we know unmet need or inadequately met need has all sorts of implications for other sectors, and particularly for the health sector. There is research evidence demonstrating the health sector benefits of investment in social care. This is not just an unmet need which somehow disappears into the background. This is an unmet need or set of needs which will have all sorts of implications for other sectors, and particularly for the health sector. There is research evidence that which Dilnot was not asked to address, is: What kind of social care system do we want? What level of need do we think the state should respond to? What do we think carers should do? There is a whole debate about that which we probably have not had.
element which would help to address some of those problems.

Professor Manthorpe: The term “unmet need” is one that we are trying not to use very much because somebody is probably meeting it in some places. When we say “unmet need” often we are meaning not by one particular part of the public purse. As Martin has mentioned, it may be the NHS, the criminal justice system or a whole range of other systems and individuals who are probably self-managing to a much greater extent than is encapsulated by the term “unmet need”. We all know that needs are generally met in some way. Probably the issue concerns the quality of the way in which those needs are met. We only need to think of the way in which needs were being met in the “Panorama” programme about a certain hospital: it was not the fact that they were not being met but the quality of care that people were receiving, or allegedly receiving.

The other point that Martin makes as to information and advice and how sophisticated that will need to be in the new Dilnot world is important. Generally, information and advice go together like a horse and carriage, but in order to give financial advice, in terms of people’s equity, pensions and capital, you would normally have to be registered as a proper financial adviser. It is not the job—and it is not within the capacity—of a very small voluntary organisation to do that. We will probably need to segment out information and advice much more than we do at the moment.

Julie Jones: Yes probably, I have two things to say about unmet need. First of all, local authorities have and will have more of a responsibility to get a better grip on what the needs are in their local areas. They can do that through the Health and Wellbeing Boards, and many of them are doing that already. Not only are they doing that, but they are changing the way they deliver services. They are changing some of the models of care. The best ones are ahead of that, but there is an enormous variation around the country. If you talk to some local authorities, they are much more on top of the sort of range of needs that are being met by different parts of the system and how that might work differently in the future, not least in the way they work with health, which I know we are coming on to later.

Q11 Andrew George: I want to be absolutely clear. You seem to have a collective view about Dilnot, the issue of the baby boomers and the equity release. In other words, there is a lot of money tied up in property. What you are all saying—and you have not said it clearly enough for my liking—or implying is that Dilnot is being too lenient on property owners and not securing sufficient release of equity into the care system. Generally, is what you are saying that the £35,000 entry requirement, as it were, should be set lower or higher? How should it be set?

Chair: Who would like to answer on Scotland?

Martin Knapp: I know that Dilnot looked a lot at the alternative models of care in Scotland and other countries. My reading of the report would be that learning the good and bad lessons from those other systems and translating them into the English context was done very well. I am not an expert on the differences between England and Scotland in their systems. The Scottish system may well have attractions, but it might not have attractions starting from where we are today. Part of the difficulty is the perceived affordability of it.

In terms of the generosity of Dilnot—again, I was not party to any discussions—I would have thought he was treading a very careful path, coming up with something which would attract pretty widespread support. Raising that limit from the £35,000 to some higher amount could well have alienated groups that are currently supporting the broader provision. I would trust in a fairly good political judgment.

Q12 Andrew George: You think he has it about right.

Martin Knapp: I think, in the circumstances, he has it right enough to open up the debate in a very constructive way.

Professor Manthorpe: One particularly interesting point is the pride that people in Scotland have in their social care system. It may be, if you unpick it all, that the finances do not add up, but people in Scotland that I have spoken to find it a source of pride that they have made a change to their social care system. How good it would be for England if, instead of all the time spent talking about problems, people would say, “We have really made some progress.” That is also a lesson to learn from Scotland.

Q13 Grahame M Morris: This is carrying on from those answers given to my colleague and the five principles on which the Dilnot Commission is based: fairness, sustainability, affordability, value for money and the systems being as simple and consistent as possible. On the point about fairness, what do you think of the suggestion received by the Committee that, in some regards, the Dilnot proposals are regressive in that those with the highest incomes—the most wealthy in terms of their contribution—would benefit considerably more than those on low and middle incomes?

Richard Humphries: If the starting point is a system in which the poorest get their care free, then, by definition, they will not benefit from any further changes in those terms. It is also the case that the richest will probably do their own thing anyway. We are unlikely to see a queue of wealthy people outside the offices of Kensington and Chelsea Social Services Department waiting for their assessment. It is the people in between—and I hesitate to use the term “squeezed” and “middle”—in the same sentence—who have more than £23,000 but not much more than that, who are liable for the full costs under the current system, that really get clobbered. They are potentially the group that benefit the most from Dilnot.
As to whether the social care system should be regressive, if we are concerned to ensure that richer older people did not benefit disproportionately from public spending, social care is probably the wrong place to start. As Dilnot pointed out, we spend about £140 billion on services for older people across the NHS, pensions and social care and, of that £140 billion, £8 billion is for older people’s social care. If we are concerned with regressive impacts, the place to start would be pensions and benefits rather than social care. Messing about with the social care funding system is probably not a good way of achieving social justice in terms of—

Q14 Grahame M Morris: You could do it fairly simply by amending the caps that are proposed, could you not?
Richard Humphries: Yes, you could. But if you set the cap too low, it becomes unsustainable. If you set it too high, that middle group still gets clobbered. It is about balance.

Q15 Valerie Vaz: Can we hear the others on that?
Chair: Would others like to chip in?
Martin Knapp: No, I am not sure I have anything else to add.

Q16 David Tredinnick: I want to ask you about the Fair Access to Care Services system. According to the journal Community Care, some commentators have said that the Fair Access to Care Services assessment system—the four different levels—is falling apart and is dead. Do you subscribe to this view?
Julie Jones: It is probably coming to the end of its useful time. When it was established it was in order to do just that, make access to care fairer, and it was a national system. Over time, the interpretation and practice on the ground around those eligibility criteria has become quite varied. There is quite a lot of evidence about how varied that is across the country now. There was an attempt to try and revisit it a couple of years ago to achieve what you are indicating, a fair way of accessing care. When you end up with a system where only the top two levels are in play in most local authorities, it has probably come to the end of its natural life. The intentions associated with it were honourable but, again, it is about the interpretation and practice on the ground as to what that eligibility looks like in Hackney and in Norfolk, and it is probably going to look a bit different. There are some problems about interpretation and behaviour.

Q17 David Tredinnick: You see this as rather emotive language and it is simply that this has reached its natural conclusion.
Julie Jones: I read Community Care most weeks and it often has emotive language, yes.

Q18 David Tredinnick: Are the Fair Access to Care Services criteria applied consistently across different local authorities?
Julie Jones: No. They are not, with the best will in the world. There has been quite a lot of research and evidence about those different interpretations. For example, circumstances that might well end up defined as “substantial need” in one authority may tip into “critical need” or “moderate” in another. It is not an exact science.

Q19 David Tredinnick: Presumably, you would like to see greater uniformity and access across social care.
Julie Jones: Yes. People would welcome that. The balance that people are searching for is between some national entitlement that feels fair and some local interpretation that takes account of where you live and what the rest of your life is like. That is a tricky balance to hold.

Q20 Valerie Vaz: The Law Commission have suggested that maybe there should be a national standardised view.
Julie Jones: Yes.

Q21 Valerie Vaz: How do you get local authorities to follow that? Is that one of the ways of dealing with it, having centrally set criteria that local authorities follow?
Julie Jones: The Law Commission is making those proposals, and the overwhelming response is that that has been quite welcome. To try and come to a point where we better understand what those national eligibility criteria are and that they are explicable to the public so that the public feels they are understandable and fair would be a step forward from the situation we have now. But it will not solve the problem of different interpretation on the ground. That is solved through local management, good practice examples and an understanding of how it looks across the piece so you know where you fit in that story. It cannot be entirely rule bound, in other words.

Q22 Valerie Vaz: Would anybody else like to add to that?
Martin Knapp: The only thing I would add is that, in a sense, you have three levels here. You have some eligibility criteria at the top level, you have what happens on the ground—managers exhibit huge variation in their interpretation of eligibility and there is a lot of “up-coding” so people get more services than might otherwise happen—and, in the middle, you often have a resource allocation system of some kind. That is how local authorities translate their eligibility into resources and there is, again, huge variation across the country. To some degree, that is appropriate in a personalised, locally driven, locally prioritised care system, but that translates, again, into lots of variability. Maybe it is an inexplicable level of variability for people who are facing a need for care services.

Q23 Valerie Vaz: I am looking to the future. How would you tie in local authorities to do that? Clearly, they all have their own priorities, and it is set against their budgets, is it not?
Julie Jones: Yes. At the moment, that is right. They are able to take resources into account. The question that will have to be answered—it is a future question.
Q24 Valerie Vaz: Do you know, as experts, how you would tie that in?
Julie Jones: We have recently commissioned some research to try and get to the bottom of that. “Are there some models that have either been done in other countries or that we think are based on the best practice in this country?” so that, when we come to the point of going from “What are we trying to do?” to “How do we try to do it?”, we are closer to being clear about that.

Q25 Chair: But are we just searching for the philosopher’s stone?
Julie Jones: No. I know what—Yes, probably, but you never stop looking, do you? There are some good examples of good practice and how to do that, and one of the aspirations must be to close the gap between the best and the rest, even if it is a philosopher’s stone.
Professor Manthorpe: An example of an area in which there has been lots of different policies and procedures is adult safeguarding, or protection of vulnerable adults. Recently, all the London authorities got together and agreed that they would have pan-London policies and procedures so that if there were allegations in one area they would be dealt with consistently. That was not done by forcing them to do it but because they saw that was a very sensible approach which could roll out to their neighbours in the home counties. There is goodwill among practitioners and among managers who do not want to have to compete, time and time again, with GPs coming and saying, “Mrs So and So gets this at that end of the street and Mrs So and So does not over there.” Translation of eligibility criteria and explaining the system to other professionals is part of social workers’ and care managers’ jobs. There is a sense of goodwill about making it clearer to people and for them not to feel bemused by what happens in one part of town and what happens in another.

Q26 Valerie Vaz: They obviously come to us as well. How do you fix that in with portability? Let us say you have people moving from one local authority to another with different criteria. I am not searching for the philosopher’s stone but for a way where someone could be a very small period of time or it could be decades.
Barbara Keeley: My local authority, for instance, to their credit, still offers care at moderate levels. If a person moved from my local authority to one where their credit, still offers care at moderate levels. If a person moved from one local authority to one where they moved in with a relative, those needs will be very different. Dementia is a good example of how difficult it is to prescribe social care because it is all very context-specific and can change rapidly from one day to another. It is around the assessment that we would want that portability, and also to give people greater access, such as those who are really troubled if their relatives are in other parts of the country needing help, that this is the place where they can go. We cannot go back to the situation of the 1960s in which we had so many beds per thousand elderly and so many meals on wheels per thousand elderly. That never worked anyway. People were always lagging behind and we areprobably still paying the price for that in terms of huge inequalities, where there are care homes in one part of the country and none in some parts of the country. It is, as Julie has said, the idea that an assessment will be professionally done, not a guesstimate, and will be thought about in the short, medium and long term. One of the interesting parts about social care is that we do not know how long people are going to be in the social care system. It could be a very small period of time or it could be decades.

Barbara Keeley: My local authority, for instance, to their credit, still offers care at moderate levels. If a person moved from my local authority to one where it was “critical” there would be a big gap in what services they had available to them. Early on in that dementia journey, in an authority where it was
“substantial” or “critical”, they are not going to get anything, are they? That is the same condition and it strikes me that this is the area which seems very unfair to families and carers.

Q28 Chair: Are we going down the right path, do you think, in trying to assess conditions and attach labels to them which, in some circumstances, can then be translated into money? That gets quite close to how the DWP does different forms of benefit entitlement if you are not jolly careful. That is the direction of travel in the social care arena. In the healthcare world, there is more of a focus on definition of good practice—what the service delivered is going to look like. I wonder whether we would make more progress if we defined what “good” was rather than seeking to put people into boxes where we could convert it into a cash sum, ultimately.

Julie Jones: We are making quite a lot of progress in defining what “good” looks like. There is a much better evidence base for social care than we have ever had before. One of the jobs of my organisation is to make that evidence accessible, not only to the front-line staff, who are our prime audience, but also to the public if they want to access information about what a good quality offer looks like, for example, around dementia care. There is, as I say, a much better evidence base now. It is not an evidence base that is always entirely research based. It is often based on user experience and knowledge of front-line staff. We are trying to pull all that information together so that people know what we should expect “good” to look like. I am more confident about that than I have ever been. Certainly, when I was a director we had far worse evidence to use. The dementia strategy and the commitments that have been made to implement that strategy nationally give us a very good way to go forward.

The other thing that is in the Health and Social Care Bill is a commitment to begin to work differently with NICE to develop quality standards that run across health and social care rather than just in health. Again, that is another good opportunity, starting in that place rather than the place you have described before.

Q29 Rosie Cooper: You have talked about defining what “good” is and I would like to pose you a question about accessibility to “good”. For example, how many weeks would it take for a social worker to get to a family to begin that assessment? I know, with one local authority, for a non-urgent—that is, non-critical—visit from an occupational therapist, it is 86 weeks. That is fact. I could go further. There will be others which are better and others which are worse. I know, again, a personal circumstance where a member of a family was showing signs of illness and it turned out to be rapid-onset dementia, which was later sorted. Within a week it imploded. It took at least eight or 10 weeks to get a social worker there and it only happened because I threw an absolute fit.

Julie Jones: That is not good.

Q30 Rosie Cooper: It is absolutely outrageous, never mind “not good”. You can define what “good” looks like and you can say, “We are getting better”—and I am sure we are—but if families and people cannot get access to it at the point at which they need it, and for a non-urgent visit for an occupational therapist in this country to be 86 weeks, it is darned outrageous. How does that fit in to all these ideas of where we are going if we cannot deliver what we have today? As to giving information and making sure that people have the information, never mind the quality financial advice—leave that aside because that is so specialist—in the first place people might go to the citizens advice bureaux and all these advocacy organisations that are suffering because of lack of money. How do you join the comments I have made up at all in this vision of “We know what good looks like,” because that does not look like “good” to me?

Richard Humphries: This relates back to my earlier comment about how access to adult social care has become worse for older people in the last five years. That is the root of it, but there is a lot of local variation as well. Here we have perhaps a policy tension between localism, on the one hand, that says local authorities must set their own priorities in response to local needs—and it may be, for all I know, in that case that local authority said, “We are going to prioritise older people who are waiting in hospital and other people will have to wait,” so there is that as well—and wanting to give people a national entitlement, on the other. We used to have a national target for assessment times, did we not?

Professor Manthorpe: Yes.

Richard Humphries: That is not how we do things now, but the information is collected about how long people have to wait for assessment. It would be interesting to see how your local authority compares with others.

Rosie Cooper: What I am trying to reflect is a view that the people out there who are listening to us debate today will be saying, “Pie in the sky. It is all very nice, thank you very much, but what happens here is not like that at all.” That is the fear we have to start to address—people’s actual experience and that which we are hoping to get to. The difference between where we are and “good” is so many light years away. I do not want people to abandon all hope in it because they do not see the gaps getting smaller.

Chair: David wants to come in.

Q31 David Tredinnick: Building on what we have been discussing, as a Committee we have been briefed—and this is, frankly, alarming—that over 80% of local authorities are offering access to care services only to people with substantial or higher needs. Do you think that is right?

This is an old building and those strange sounds we are hearing might be the mice in the Members’ Dining Room.

I will go back. Do you think that that is likely to be the case? That is what we have been told, that over 80% of local authorities are only offering services to those who are better off?

Chair: Those with substantial needs.

Q32 David Tredinnick: I am sorry, but I got distracted by the noise. We have been told that over 80% of local authorities are offering access to care
services only to persons with substantial or higher needs. Do you think that is likely to be correct?

Julie Jones: Yes.

Professor Manthorpe: It may be an underestimate, I would think. The lady there said her local authority was working with “moderate” but I am finding it hard to count, more than on the fingers of one hand, the number of other authorities who work with “moderate”.

Barbara Keeley: It is 15 or 18.

Professor Manthorpe: Of course, there are many interpretations of “moderate”. Today’s “moderate” may have been yesterday’s “critical”. It is not that it is written in the philosopher’s stone.

Q33 Chair: It works both ways, does it not? If the only cases that get any care are “substantial”, then individuals who would previously only have been called “moderate” tend to be classified as “substantial”. Is that right or wrong?

Professor Manthorpe: No. Social workers make some very hard decisions with people who they know, very clearly, will be arriving at the hospital gates or somewhere in the system. Such is their inability to meet their needs currently—and many of them will have now to go to a panel to wait for approval of some sort for funding for a support plan—that delays and rationing within the system are very common.

That is not what people went into social work or case management for. They certainly did not go in, as Rosie Cooper talked about, to tell people that there would be a delay of 80 weeks, or not to get round to see somebody in crisis.

Q34 David Tredinnick: Who is filling the unmet need for social services? Is there anybody else?

Professor Manthorpe: People are paying for their own care and support. People’s families are paying for their own care and support: people’s families are taking time off work, doing shift work, perhaps bringing in relatives or perhaps going overseas and seeking people to move into their own homes. There are a variety of ways. The unmet need that we talked about before is being met in a sort of way. People are also turning up at the hospital gate and staying in hospital because there are no other resources for them. Also, perhaps, people are moving too quickly to residential care. We have not talked about residential care in the way that—

Chair: We will, if we move on.

Professor Manthorpe: Disappointment means you might end up there sooner than perhaps you wanted to.

Q35 Andrew George: I want to go back over the issue of the concept of “good” care and how substantial those assessments are, and particularly, if the Institute takes a view on this, whether that view—and it is rather challenging—is too superficial, especially in the context of residential care. If we are only looking at the outputs of the service and not at how threadbare the inputs are, we may get an impression of the facade of how “good” the service is but not take into account the fact that the staff ratios have significantly changed to the detriment, the acuity particularly has gone up, as we have defined in terms of the definition of where support services come in—so acuity has increased—and, as others have mentioned already, you are paying staff where you are paring those resources, frankly, to the bone. How sustainable are services? They may be good at the moment, but is there not a proper assessment of the inputs of the service other than the rather superficial assessment of how good that service happens to be in spite of all the challenges that it has?

Julie Jones: I think I said we know a lot more about what “good” looks like, not that it is good everywhere. We have a lot of good examples of that right across the country and in all different parts of the social care system, including residential care. We also know that good quality, judged in terms of the outcomes for the individual, is not always dependent on money. It is a necessary but not sufficient part of the determination of “What does good look like?” If you ask service users and their families what they care most about, the sorts of answers you would get are kindness, compassion and consistency, so low turnover of staff, those things that are about building relationships with the person who is there to provide the care. Of course, that is associated with money, but there is not a direct causal link with how much money you have and how good you are. There is a lot of research evidence about that. We know that, right through the system and across the country, there are good examples of what “good” is, and we celebrate that when we can. There is not enough of it and the gap is still much too wide. What I was saying is there is no excuse for not knowing what “good” looks like, because there is a lot of evidence about what it looks like now. There are often reasons why people do not feel they can aspire to that in their current circumstances. I did not mean to be superficial and, if I was, I apologise.

Q36 Andrew George: Do you not acknowledge that there is bound to be an interrelationship between stresses in the service with regard to patient ratios, pay and other stresses and the good outcomes?

Julie Jones: Yes. But you do, then, have to ask yourself why, in very similar circumstances, with different levels of resources and different situations and similar needs being met, one organisation does it very well and another service does it far less well. There are differences, even when you take account of all those things that you have described. We know that, with the same level of input, you could get better outcomes depending on all sorts of other things that are associated with what “good” looks like in social care delivery. It is not as straightforward as you suggested—that the one over there getting loads of dosh is fine and the one down here that is not is awful. We know that because we ask service users and their families about what it is they most value. What I am trying to say is that money matters a lot but it is not the only thing you should be thinking about in terms of “What does good quality social care look like?”

Q37 David Tredinnick: What kind of risk do you think individuals face following the tightening of the Fair Access to Care Services system criteria, please? If the criteria had been tightened up—generally
speaking, it is harder for certain groups—can you quantify that in any way or is it generally much more difficult all round? You have individuals who are going to be affected by the change in the tightening of the criteria. Do you have any evidence to show that a particular group or range of individuals has been disadvantaged more than others and is there anything you want to tell us on that one, please?

**Professor Manthorpe:** We would all recognise—and you, in your constituencies, will recognise—that a wide variety of people who are in moderate need will appear and give rise to cause for concern, but there will be many people, and particularly older people, who say, “I am not bad enough.” So it will be a hidden population. I am sure we have all met people who say, “I am not that bad” and you think, “My goodness, I think you are.” It will be a hidden writ. Whether or not that will be around deprivation or it will apply more in rural areas than urban areas or it will apply for people with conditions that perhaps have some stigma around them and they really do not want to make a public fuss on their or their relative’s behalf is up for grabs. But I do not think we have evidence to say that it will be women or this particular group as opposed to that. It will be locally determined and depend upon the strength of people’s user groups and lobbies.

**Q38 David Tredinnick:** Thank you very much. This is my last question. To what extent would greater efficiencies and/or renovation in social care counteract access restrictions?

**Richard Humphries:** If we look at what we know about efficiency gains in adult social care, the sector has generally done very well. Adult social care has probably generated more efficiency savings in the last three to four years than many other parts of the public sector, including central Government, may I say. If we look at the position for this year, we know that local authorities are taking £1 billion out of their adult sector, including central Government, may I say. If we look at the position for this year, we know that local authorities are taking £1 billion out of their adult social care budgets, but they aim to make—I think it is—£78 million1 in efficiency gains. That is the aim. That is a very ambitious and, possibly, idealistic target given that all the low-hanging fruit will have gone by now. Personally, I would be sceptical of how much more can be squeezed out of the existing pot. There are two areas that need to be explored, however. One is the substantial variation from one local authority to another. We have already heard an example of that, and why it is you are four times more likely to be admitted into residential care in one local authority than you are in another. The other potential prize is around the integration of health and social care, the closer collaboration and some of the gains that will come from that. It is those areas, rather than the pursuit of efficiency as such, where I suspect we have probably exhausted the obvious wins.

**Julie Jones:** I have two things to add to that. When the Department of Health published a report on the use of resources across local government—and Richard referred to it—which drew attention to that very wide variation, there were two areas where there seemed to be some opportunity for improved efficiency and a more effective offer as well. The first was in the amount of money that is spent on assessments and repeat assessments, with too much money going into the front end of the system—the assessment part. Local authorities are to reduce their spending on assessment by making them more efficient, perhaps by doing them jointly with health, only doing them once and possibly asking people to self-assess as a way into the system. There are some efficiency gains to be had from that. The other is in the developing service around reablement. In the past, people would have come into the social care system and probably never moved out of it again. Once you are in, you stay in. There was no managing of turnover in the system at all. What the reablement agenda has been able to do is offer people the opportunity to recover as well as they possibly can, as quickly as they can, in order to sustain an independent life. What reablement offers is an opportunity not to get locked in the system with the offer that was made on the day you came in. That, again, is an efficiency gain, but it is also effective. People prefer to be helped to recover and recover their more independent life, too. Those two developments have given us some efficiency gains already, but we are not there yet. There is a lot of variation around the country in how well that is happening.

**Q39 Rosie Cooper:** I have a couple of questions, but a very quick one for Julie, if I may. CQC, when they were with us, said they did not go to people’s homes to ask them questions about the quality of the service that they received. You mentioned that people tell you about that. Do you have any difficulty in engaging with service users or residents in their homes about the quality of service they get?

**Julie Jones:** We do not have responsibility to do that directly with the residents. We are quite a small organisation and do not have the capacity to do that. We have to do that through employers—whether that is local authorities or the very large market—and use the material they gather about themselves, or independently-commissioned work. For example, King’s College may do the work and we might well commission, for example, some of that work. We would draw on material from wherever it is. All local authorities will have good local information about what works well and what does not. If the voice of the service users and their families is not writ large in all that, it is not good enough. You are right to ask, “How do you capture that information?” When designing what we hope is helpful information for the workforce, we would always include service users and their families in the design of the questions to ask as well as helping us with the interpretation of the findings.

**Q40 Rosie Cooper:** Thank you. That is a big hole at the core of where we will go, I am sure, in the future, but thank you for that. Very quickly, people are worried that personalisation might be used as a cost-saving vehicle, especially in the economic downturn. Do you believe there is any evidence that is happening, and do you think that personal budgets meet carers’ needs more cost effectively? I would go on to ask: does the local authority have a future role in commissioning in a

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1 Note by witness: the correct figure is £681 million.
personalised social care system? What is the future in that area?

Julie Jones: The conversation about personalisation always gets stuck on personal budgets. A personalised social care service is much more than the sum of personal budgets, but personal budgets are one of the very important levers. It started with direct payments way back when—a very slow start—and pretty well focused on our people with physical disabilities and then with learning disabilities and their families. Direct payments, now personal budgets, are with 30% of the people who are dependent on public funding and have an assessment from a local authority. We are beginning to get the hang of where the personal budget sits as part of the whole personalisation story. Many people are saying that they do not want a direct payment. That is still growing in numbers, but much more slowly than the number of people with personal budgets. There has been a report published by the Association of Directors of Adult Social Service in the last week or so on where they think they are in delivering the whole personalisation story, which has, I have to say, great support from around the country in terms of, “When it works well, it is what people prefer, but it is not for everybody and it is not all the time.” Personal budgets are not designed to save money—that is not what they are for—but what people who have a good personal budget and are using it well tell us is that they spend their money better when they are able to choose and control what makes a difference to their lives than the previous system allowed them to do. It is “popular” and all the research from around Europe says it is popular too.

Q41 Valerie Vaz: Can you describe those sorts of people?

Julie Jones: It started with a big focus on people with physical and learning disabilities. The start with people with mental health problems was slower, where there was a concern about capacity, and also with older people. We published quite a lot of material about, “What are the barriers?” “What is getting in the way of allowing people, in those circumstances, to make good use of this too?” Now we are up to the 30% and the aspiration is to get as close to 100% as possible by 2013. It is inevitable, because of who is in the system, that far more older people will be offered this option. They do not always want it.

Q42 Valerie Vaz: I wanted you to describe people who are happy with the system. What kind of people are they?

Julie Jones: They are often people who are well supported and do not feel stranded with it as an offer. If you are given either a direct payment or a personal budget without any information, advice and support to know how to use it well, then, clearly, that is not acceptable. It is not good practice.

Q43 Rosie Cooper: Do you think that there should be a health care personal budget as well as a social care personal budget and should they be integrated?

Julie Jones: There are some pilots round the country testing this out and there are some early findings about that. I do not know whether Richard or Martin know more about the early findings.

Martin Knapp: The early findings are similar to the early findings with individual budgets for social care. There are various operational challenges in getting things in place. It is changing people’s attitudes to holding those budgets and it is changing the attitudes of the staff they work with to work with them. But it seems to me a very logical development for people with long-term health conditions to be given a much greater say in how the health money is spent on them in a way that has been successfully demonstrated as a potential advantage in the social care system. The other thing I would quickly throw in is that Gill and I were involved in the evaluation of the individual budgets pilots and there were lots of potentially good outcomes from that as well as some challenges, but, to me, the fact that personal budgets proved to be cost reducing would not be a problem at all. You would not want to set out to design a system in that way. If this was a way of achieving efficiency gains within social care in a system which is, we like to think, outcomes-led, it would not be a bad result—if it meant the money was spread more effectively in other ways—but it would be wrong to set out that that was the primary goal, for sure.

Q44 Barbara Keeley: There are some services, though, that I have heard are being discontinued in my own area that cannot be provided by personal budgets. If you take the services I heard about, there was a good service to carers and people with dementia—it was support for the people with dementia and a drop-in for their carers at the same time—being discontinued because of the implementation of personal budgets and a kind of active individual case management being done by a voluntary organisation for older people being dropped. You cannot use your personal budget to buy a drop-in to support your carer. There are certain services which might exist because they are allocated across the piece. Everybody effectively chips in a part of it. By giving the money to the family—the one person with that—that service cannot be provided. I know it is a difficulty now, between my local authority and the local organisations that were running services, that services are being dropped. It seems to me that that is not a good outcome. That is not a good way forward. If everybody moved on to a personal budget, how could they buy those things?

Richard Humphries: One of the judgments each local authority has to make is how much of its total resource it puts into universal services—what we call, in the jargon, “the universal offer”. That may include things like drop-in. It would certainly include information, advice, support and brokerage to help people and how much it puts directly into the pot for direct personal budgets so that people have more to spend. There is an important balance.

Q45 Barbara Keeley: But then we are back to the cuts, are we not? There is not the luxury of hoards of money, is there?

Richard Humphries: No, there is not. But, as Julie Jones has said, we have this—I think it is—£2 billion
that local authorities spend currently on assessment and care management. Is that the right amount? Are we spending too much on that to say to a heck of a lot of people, “Sorry, you are not entitled to anything?” Or should we spend less and put more into information and advice? Or should we put it all into personal budgets? These are, essentially, local choices.

Professor Manthorpe: The carers’ drop-in centres and the services you describe may not only be the responsibility of local authorities. Clearly, they could be places where there would be co-location with NHS staff, or perhaps rooms for DWP staff to be engaged. As you say, it is impossible for personal budgets to build a carer’s resource brick by brick—that will not work—

Q46 Barbara Keeley: No, it is not a building. It is a service.

Professor Manthorpe:—or to pay for it in that way. It is about saying it is part of the community in the same way as accessibility and information and so on, but it does not necessarily have to come out of personal budgets, and indeed not necessarily out of local authorities on their own.

Q47 Barbara Keeley: I am saying, in my experience as a local MP, that these things are slightly falling apart because of the move to personal budgets. It is an observation. It is not a theoretical thought. What is happening in my locality is that services are being lost because of moves to personal budgets. It seems to me that, possibly because of cuts, if those things should be in the universal offer, then obviously they are not.

Q48 Grahame M Morris: Does the move towards personal budgets work against integration?

Professor Manthorpe: It may shift the level of who is doing the integrating. If you are receiving a personal budget, you may well want to buy some aids and equipment to make your life or your relative’s life easier. You are the integrating force, perhaps, as the consumer. You may find that there is nothing you can purchase, so it is a different take of integration in that you, as your own care manager, or your relative’s care manager, are integrating a number of financial streams.

Q49 Grahame M Morris: Strategically, if health and social care are working together and local authorities and the NHS are designing services together, with integrated pathways, would personal care budgets undermine that, or would they complement that?

Julie Jones: They should not undermine it, should they, if you start where Gill has, with the individual person? The other job of the local authority is to try and shape a local market so that there are things to buy with your personal budgets or your direct payment. It is a very difficult transition that is happening at the moment. To be doing it at a time when resources are so stretched is also very challenging. I do not want to underestimate how difficult it is to try and shift a complete way of delivering services with all of the culture, behaviour and workforce changes that have to go with that at the same time—it being in the circumstances you describe, where local decisions are looking pretty harsh.

Q50 Barbara Keeley: It has been said that this is a move that is going to be very slow and long term. As a general comment for Ms Manthorpe and Martin Knapp, could you tell us if you think that has slowed down? If it was always going to be slow and long term, is it now, because of cuts, slower and more long term?

Professor Manthorpe: I am a 17-year person myself. I think most things take 17 years. In this particular instance, the combination of the cuts and the transformation will have accelerated the closure of many things you were referencing, such as both carers’ buildings but also day centres. The work that we have done points to the day centre as being perhaps that building-based service which will decline to an extent we have never really seen before, and we will not really know the ripple waves of that. Maybe it will not be 17 years. There will be some very rapid changes within local authorities. I can think of some where there are three main day centres for people with dementia and there will be one very shortly. That will be a huge change to the landscape, not only affecting social care but health colleagues who rely on day centres as the outpatient bit of their hospital and clinical work. They will not be there any more.

Chair: I am conscious that we are running out of time. Dan wants to pick up Grahame’s question about integration and the effects.

Q51 Dr Poulter: I have a couple of quick questions on integration of services. This is going to be key, I think, to the way forward. Currently, what evidence is there that integrated commissioning is taking place between primary care, secondary care and adult social care? How effective is that?

Richard Humphries: There is not much.

Q52 Dr Poulter: Not much, exactly. That is what I am driving at.

Richard Humphries: There are some good local examples but, I have to say, examples that are being a little bit undermined by the current changes.

Q53 Dr Poulter: The national picture is not much, but there are some good—

Andrew George: Undermined by the current changes.

Q54 Dr Poulter: The national picture is that there is not much integration but there are some good local examples.

Richard Humphries: I think your question was about integrated commissioning.

Q55 Dr Poulter: Yes, indeed.

Richard Humphries: There are lots of small-scale examples of integrated services. There are some examples of where PCTs and local authorities have come together to jointly commission, and there are a few examples of where they have come together to have a single integrated commissioning unit.

Q56 Dr Poulter: But it is a bit patchy at best.
Richard Humphries: It is extremely patchy, as is the overall performance of the health and social care and working together.

Q57 Dr Poulter: Would it be fair to say that there are not necessarily the financial incentives or drivers in the system at the moment to encourage integration of care between adult social care and the NHS? For example, we made the point earlier that 82% of local authorities are offering access to care services only to people with substantial or very severe needs. But if we are talking about people who have more moderate needs—those who may trip up and fall over at home because of those moderate needs—and they are not getting access to the services they need, that has a very substantial impact both financially and in human terms on the NHS through hip fractures and those sorts of things. Is this a key problem?

Richard Humphries: Yes, in short, because if you look at the financial wiring diagram of social care in local government and you look at that same diagram for the NHS, it is totally different. The incentives are not there. One positive development recently has been the decision in the last spending review to allocate £1 billion of the NHS budget for social care. That has really incentivised people in the NHS to take an interest in what social care money does for them. It should be much more than the £1 billion. We should be looking at the whole £120 billion or whatever is the current combined spend of social care and health. It is those practical incentives that will drive some of this and encourage people locally to look at what is happening to the money.

Q58 Dr Poulter: The problem at the moment is that you have separate budgets. Do you think having a confluent budget that follows the person or patient would be more effective?

Richard Humphries: Absolutely. The outcome you want is to get the resources aligned to the needs of the individual, whether that is done through pooled budgets, community budgets or place-shaped budgets—as it used to be called—or whether it is done through shared decision-making. The resource does not necessarily need to be integrated. The key thing is that health and social care partners are agreeing about where the money goes. It is about following the money, to put it bluntly.

Q59 Chair: If commissioners are supposed to be driving change through a system at an unprecedented rate, it must follow, must it not, that single integrated budgets are the most powerful weapon that could be put in their hands to achieve it?

Richard Humphries: That would be a logical progression, particularly if—Chair: It is that bad.

Richard Humphries: I have long given up commenting on logic in matters of health and social care policy, Chairman. If clinical commissioning groups and local authorities can work together in a partnership, there are all sorts of possibilities about bringing those resources closer together that perhaps were not as apparent in the days of PCTs.

Q60 Barbara Keeley: Could you say how the Health and Social Care Bill will impact on that? It has been slow, it is very patchy and it is only integrated in certain places. How will the churn we have currently—

Richard Humphries: In the short term, there is a risk that it will undermine some of those existing good examples of local integration because of the merger of PCTs into PCT clusters. A lot of those positive arrangements in places like Herefordshire, Wigan, Torbay and Blackburn have been around PCT local authority relationships, and that will change and presumably will have to be renegotiated. There is also a danger of a lot of the existing relationships, the chemistry, people that have been in key posts locally for a long time, leaving. That always disrupts partnerships, and we know that one of the success factors is about evolution of trust over a period of time and local leadership.

On a positive note, Health and Wellbeing Boards potentially have the opportunity to bring together all the key players in the local health and care economy in a way that has not necessarily happened before. The arrival of GP-clinician leaders represents new kids on the block, and in some places there are some very interesting and encouraging new conversations going on between GPs and social care leaders. In some places it has rejuvenated tired relationships. It has brought in a new set of players. It has always been very difficult, certainly in my professional experience in the past, getting GPs engaged with joint working. The tide may be turning. There are grounds for optimism but there are also concerns about the risk because of the short-term impact of the changes.

Q61 Chair: Does anybody else want to comment on that? No.

One question we have not covered, which I would like a brief comment on before we conclude this session, is the question of whether you support the extension of Monitor’s role as a regulator into the providers of social care, partly against the background of the discussion we have had of integrating the service as experienced by the service user.

Martin Knapp: There has long been a need for some form of oversight of the social care markets. Social care markets have been far more complex than healthcare markets forever, but we have not had that. Social care markets are still pretty competitive, but there have been some famous difficulties recently which suggest that the local authority oversight of quality in providers has generally been okay but the oversight of economic wellbeing is sadly lacking locally and nationally. I am not an expert in economic regulation, but I would see a crying need for a better system than we have now. Whether that is Monitor or somebody else, I do not know.

Q62 Chair: Do you, in principle, warm to the idea of a single regulator looking across the health and social care arena?

Martin Knapp: There would be advantages in that. There could be disadvantages if the lens that is used is a health lens or a health market lens and does not appreciate the different situation within social care.
have not thought through what those developed risks might be, but there is a long history of people looking at social care through a health lens in other respects, and that has not been terribly helpful in some cases.  

Professor Manthorpe: It will have great advantages in looking at the work, for example, of healthcare assistants and people who are called care assistants and really thinking about the ways in which these workforces, which have generally been on different planets, can be brought together and integrated to some extent.

Richard Humphries: We need to be very cautious about applying a model of economic regulation that has been developed in the NHS context to the fundamentally different nature of the social care market where you already have 40,000 independent providers. I am conscious that hard cases make bad law. Before one considers who should do the economic regulating, it is necessary to be very, very clear and think through exactly what needs to be done. Given that we have 17,500 care homes, for example, about 170–175 of those each year are likely to close. You need a degree of exit and entry because we want poor quality providers to move out of the way to make way for providers that come in, do a better job and innovate. We have to be very careful to adopt a risk-based and proportionate approach. The Monitor model of a full-blown authorisation and failure regime could make matters worse.  

Chair: That is interesting.

Q63 Valerie Vaz: Would you have CQC instead?  

Richard Humphries: There are other options.  

Chair: The thought going through my mind was that you were drawing a distinction between health and social care and saying in social care it is important that non-performing providers are exited. I wondered what the distinction was between that and healthcare, but that is perhaps a discussion for another day. Thank you very much for your evidence.

Examination of Witnesses

Witnesses: Heléna Herklots, Services Director, Age UK, Jeremy Hughes, Chief Executive, Alzheimer’s Society and Bruce Moore, Chief Executive, Hanover Housing, gave evidence.

Q64 Chair: Thank you very much. I think all of you heard most of that last session. We will want to cover some of the same ground and some different ground. Perhaps I could ask you to begin by introducing yourselves and telling us where you come from.

Jeremy Hughes: Thank you. I am Jeremy Hughes, Chief Executive of the Alzheimer’s Society. We are responsible for supporting people with dementia through care services, policy and public affairs work and research.

Heléna Herklots: I am Heléna Herklots, the Services Director at Age UK, which is the organisation formed by the merger of Age Concern and Help the Aged.

Bruce Moore: I am Bruce Moore, Chief Executive of Hanover Housing Association, a housing association specialising in housing for older people throughout England and parts of Wales.

Q65 Chair: Thank you very much. Could we start, but possibly not spend quite as long as we did with the previous group of witnesses, on Dilnot and where you feel that process leaves us? First of all, do you agree with the conclusion of the previous board of witnesses? They were a bit sceptical as to whether the recommendations were practical and feasible, particularly given the current climate. The advantage of what the recommendations are saying is the clarity they provide, both for potential users of services and for providers, and, indeed, for the financial services industry in thinking about possible products. We would see it as an essential step forward. Clearly, there is more work to do on what that would look like in terms of implementation. What it shows is that mix of personal funding and state funding. You can play with the ratios there, but you do need clarity for people about planning. If you look at what kind of long-term care insurance has not worked to date, it is because people have a great deal of uncertainty about the system and providers have a lot of uncertainty about how to price their products and what the regulatory system would have been. That has, therefore, prevented some developments that might have been helpful. We think the Dilnot recommendations provide a strong case for reform and the starting point.

Jeremy Hughes: I would support that. Dilnot is the best thing we have on offer. Therefore, we should probably try and make a go of it. Picking up on the earlier discussion, there is a value in looking at the equity release of property, but it is a short-term value, as was discussed in your earlier session. Of course, an insurance-based product may not yield value immediately so maybe there is a stop-gap benefit of something that looks at equity release. The insurance system is more equitable, potentially, but needs to be compulsory to work. To support what Heléna said, we did some recent research that showed only 4% of the people we surveyed had any form of social care insurance and 35% of people had not considered it because they did not realise they were going to have to pay for it. There is a real gap there.

Bruce Moore: I concur. The advantages Dilnot provides are the sense that there is a promise of some
point of clarity—some certainty into the system—which allows the other issues to come through. If you have certainty about where the system’s parameters are, the quality and other standards can start to come through. The sense of not having a cap on people’s liability would deter the insurance model from developing or from making other provisions about releasing that amount of equity to address those potential care requirements. The certainty and getting that right balance of personal and state support around that framework is essential.

Q66 Chair: There does seem to be a fairly broad basis of support for the Dilnot formula. Is that something you think could be legislated quickly or is it inevitable that it waits for the broader review of social care and legislation to follow? Have you done any work to look at what we could do immediately or in the short term to get the process moving?

Heléna Herklots: There are some elements of the recommendations which we can move on straightaway and do not require legislation. One key one is information and advice, for example. Whatever the reforms are, people have to know about how the system works and what they can expect. Things like that, where Government can work with the sector, with local authorities and health trusts, are really key. Other elements of the reforms that would be pretty quick to introduce would be things like the portability recommendation as well. It is probable that there is some work to do to unpick what are the elements that can be moved forward on quickly while waiting for the necessary legislation for other elements. That sense of “Now is the time to move” and getting momentum is really important.

Q67 Chair: Taking your point about getting some momentum behind it, if there were some specifics that could be drawn out and implemented quickly, it would be interesting for the Committee to know what those are, in your opinion.

Bruce Moore: I have a slightly different view. There are so many interconnected elements to all these components that you have to have a cohesive package. Quite peripherally, advice is always going to be a requirement for whatever system we have, but that does not get to the heart of any real reform. With any of the bases of reform you need to have a package that has coherence and interrelates, and perhaps Dilnot did not necessarily show where all its boundaries and interfaces were going to work. It needs to be worked up as a package because we know that if you effect something here it has a knock-on—perverse incentives or other consequences elsewhere within the system. You need to have cohesiveness to the system for it to be effective. You have residential care, the domiciliary and the other components of that. How those will interface has to be seen as a whole in that process, and the funding and where that comes in.

Jeremy Hughes: To add to the point already made, two aspects of Dilnot could be implemented quickly. First, a change in the means-test threshold from the £23,000 it is currently at, particularly for people with dementia. With many years of potential cost of social care, they are being hit with what we have called “the dementia tax” because it is a disease that is met through social care support rather than NHS support. The other area is the national eligibility criteria that Dilnot picked up on and which was also picked up on in the Law Commission. Some immediate movement there would produce a far more equitable system that would support people better.

Q68 Andrew George: On that last point, you say that could be implemented almost straightaway. If you move from a threshold of £23,000 to £100,000, it is going to cost the taxpayer a lot of money.

Jeremy Hughes: It will cost something but it will not cost an enormous amount. Also, there are parallel changes in the way the system operates that could be improved. To take, again, a dementia example, which I know, there is a report published by The Health Foundation this month that says if people with dementia moved out of hospitals two days earlier than they currently do, when they have gone in for other purposes, it could save £700 million. That is a significant amount of saving.

Chair: That is assuming you close the hospital.

Andrew George: That is the holy grail that I think all health systems—

Jeremy Hughes: That is the overstepping of people with dementia.

Q69 Andrew George: Can I, first of all, apologise in advance that after these questions I have to depart? It is not because I know that I will be disagreeing with everything you say and walking out in protest.

In relation to the hotel charges under the Dilnot recommendations, the £7,000 to £10,000 per annum cap that should be set, do you see any potential unintended consequences, given your intricate knowledge of the way in which the system works within your own sectors? In particular, for example, within a residential setting, this might mean that certain clients end up with the rooms with no view, eating beans on toast and sleeping in nylon sheets for weeks on end. Could there be consequences? Could there be regional variations? Have you considered whether this is a good thing or a bad thing?

Bruce Moore: It is a good thing. It levels the playing field against residential care versus extra care. At the moment there is an incentive on social service authorities to commission extra care because the housing, the board and lodging costs, are met through housing benefits. They are not comparing like with like. From the local authority’s budget perspective, they much prefer extra care because the housing costs are met through housing benefit and they only have to pay the care costs, whereas, by placing somebody in a residential care home, they have to pay the whole of the cost. It is, again, those differential rates. In terms of Dilnot, I see it as having the board and lodging element identified. If somebody wishes to pay to have a higher quality meal, a better room or whatever else, then they can always top that up, as it were, but having that allowance in there is a positive move. It will make sure that we make more sensible decisions across the piece.

Heléna Herklots: One of the problems is disaggregating those costs. In principle, it is right.
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Whether that level is correct probably needs a little more looking at, but there needs to be transparency so the resident and the family are very clear about what they are getting for that money. It brings up a wider issue, maybe, about the quality of care in the care home sector overall and the way in which that can be improved, both through contracts and the regulatory process. There are some risks with it, but it will help to drive transparency around costs in care and what the users are paying for.

Jeremy Hughes: The difficulty is in drawing the line between what are hotel costs and what are social care costs. Where does a meal provided become a hotel cost and where does helping the person eat the meal provided become a health cost? There is that blurred boundary. The difficulty with setting a ceiling on it in the way proposed—the £7,000 to £10,000—is whether that is going to reduce quality of things that are essential rather than things that are marginal. The advantages are in getting a level playing field across residential care to domiciliary care, so there is a major plus there.

One of the things that would also need sorting out is the disparity between NHS continuing care, which includes support for all costs, compared to social care funding, which only covers, as we have talked about, the social care costs rather than the hotel costs.

Q70 Andrew George: But there is a clear line. If you are being assisted to eat the meal, that is care.

Jeremy Hughes: We have had different assessments. We have case studies of people who have been assessed in different ways and people who have been moved from one assessment to another being told that what was previously called “social care” has now become “living costs”. There is quite a disparity in the way that is being interpreted.

Q71 Andrew George: Do any of you think there might be a risk that setting a cap might set a cap on what we might, perhaps pejoratively, describe as bog standard services below that level? In other words, people will feel that they would like to top up to above this bog standard. Is there a risk that the cap may be set too low, or even too high?

Bruce Moore: The standards at the moment are very low. The whole benefit of Dilnot is that it sets a framework on which you can then have some certainty and build from. Having said that, there is a base level of what we would regard as an acceptable board and lodging standard which allows people then to say, “I want an enhanced form of that.” At the moment, the standards of board and lodging, if you like—the accommodation side—are probably one of the worst in Europe in terms of the standard of residential care accommodation. Anything we can do to enhance that has to be welcomed.

Q72 Andrew George: You think that, concomitant with this, would need to be a clear definition of what standard—

Bruce Moore: What is acceptable that goes with that, yes.

Andrew George: Thank you.

Q73 Rosie Cooper: This whole area of social care funding is a nightmare. I was talking to a director of social services who said to me, “If you guys can, do something to help sort it out, only there are some days I don’t think I understand it”. We are expecting individuals to engage in that difficulty.

Listening to your conversation with Andrew and talking about standards and the fact they are very low already, what most people hit on is, for example, that local authorities are reducing the amount they are paying for residential places to £420. I know with one authority it is about £423—very, very low. Costs will be higher than that so, in order to function, that care home will charge any self-funders even more to make up that gap. In the new world of transparency that you are talking about, how would that work? Which fool would offer to go and pay somebody else’s bills?

Heléna Herklots: As soon as you start looking at reform packages, these are some of the questions that come up. That kind of cross-subsidy, if you like, has been in place for many years. I am not sure I can give you an answer to what the implications of that are, but, at Age UK, we certainly get quite a lot of older people contacting us about that sort of issue. They feel it is unfair that, in a sense, they are subsidising other places in that care home.

Q74 Rosie Cooper: Local authorities are driving down the amount of money for their places and, if you have that transparency, people are not going to volunteer to go somewhere and pay other people’s bills. Therefore, is the standard of quality going to go down or do those homes which deal with local authority-funded care they are booking 15 minute visits, which, of course, for somebody with dementia, is often worse than useless. You have barely got through the door and you are expected to dress, feed and look after the personal needs of somebody in 15 minutes. You cannot do it. There is a need to expose the failures of the system in order to get change.

Q75 Rosie Cooper: I hear what you are saying but I have knowledge of a person with very serious dementia, who was doubly incontinent, being dealt with on 15-minute visits, with changes and all of that, and the distress there—phhwwt, tsch, tsch, gone. Yet we allow it and we all concur. We know it is happening. How is it okay?
Jeremy Hughes: I am saying it is not okay, but the public need to become increasingly aware of it. An interesting point that came from your previous session—which I think is a really positive element within the Health and Social Care Bill—was about the potential role for NICE to look at quality standards spread across health and social care because, at the moment, we have a real disparity. We have a hidden agenda of what quality standards are expected in social care. It is far less well inspected and policed than health standards, which allows the kind of situation you are describing to exist.

Q76 Rosie Cooper: What do you think of local authorities who charge by the minute?

Jeremy Hughes: Do you mean in principle? It is hard. The charging system exists. We cannot get away from that. We have a charged social care system and we have, if like, an uncharged health system, so we have that disparity. How the local authority calculates its charging again comes back to the point about it needing to be transparent and people needing to see what they are getting for the money they pay or that is being paid for by the state. Exactly how they account it is not the issue. It is about the transparency, as you were saying, and the visibility.

Q77 Rosie Cooper: I must admit to having been horrified, when we were taking evidence from the Care Quality Commission, to find that they are inspecting hospitals and all that kind of thing but not care in your own home, the one area where you are, almost, in a systems sense, at your most vulnerable. Who inspects that? Who sees that what you need is being delivered? The Care Quality Commission relies on the paid provider to tell you that they are doing it. Every Member of Parliament will know, especially in the bad weather and various things like that, people are supposed to have four visits but will get one, and yet they still pay for four.

Jeremy Hughes: We published a report at the beginning of this year which found that 50,000 people who are fixed for a period of five years or 10 years, or whatever. Perhaps concerns are raised by patient groups, as you say, or relatives, about the quality of care that may be provided at certain care homes, or even in the quality of domiciliary care that is provided. Those contracts are fixed for a period of time. Have you any concerns about the mechanism, the quality of negotiation of those contracts by local authorities, or the ability those local authorities have to intervene when there are concerns raised about those contracts? There are also issues of training of staff and all those sorts of things that I am focusing on.

Heléna Herklots: There are two things. One is that it is quite difficult, if you are an older person or a family, to know where to go. If you have a concern, where do you go? Do you go to the local authority or straight to the Care Quality Commission? We can make it easier for people, first of all, to register those concerns. The second is the speed of response. What is the speed of response of looking at that issue? Is it an isolated issue or is it systemic with that particular provider? The contract development process is critical. It needs to look at things like outcomes for users and not just the mechanics of the contract. It should be regularly reviewed and should link into the feedback process on the quality of care.

Q78 Dr Poulter: I have a quick question following up on that. The Care Quality Commission will look at standards in health care or adult social care in care homes. What is your view of the role currently played—is it adequate—by local authorities in monitoring the contracts and the quality of care in care homes? Do you think there could be an enhanced role for local authorities?

Heléna Herklots: The whole area of quality, both in care homes and domiciliary care, is key. There are huge issues around the funding of care being in crisis, but there is a deeper and hidden crisis around the quality of care. One of the things we have found incredibly powerful at Age UK is involving older people in inspection of care. We run something called the Experts by Experience programme, which is trained older people going into care homes and hospitals. We have recently started some work around them looking at the quality of domiciliary care alongside the formal inspectors. That uncovers things that otherwise would not be uncovered because people will talk to another older person about something in the way they might not talk to a so-called professional. We need to be a little more imaginative about the way in which we assess quality, who we bring into that process and, picking up the earlier point, making sure there are not any closed doors—that people are not isolated and that there is that element of inspection.

Q79 Dr Poulter: That is very useful. To take an example, a local authority would award a contract for a period of five years or 10 years, or whatever. Perhaps concerns are raised by patient groups, as you say, or relatives, about the quality of care that may be provided at certain care homes, or even in the quality of domiciliary care that is provided. Those contracts are fixed for a period of time. Have you any concerns about the mechanism, the quality of negotiation of those contracts by local authorities, or the ability those local authorities have to intervene when there are concerns raised about those contracts? There are also issues of training of staff and all those sorts of things that I am focusing on.

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Q80 Dr Poulter: Have you concerns at the moment that local authorities are doing this in as proactive and effective a way as you would like?

Heléna Herklots: I suspect my answer is similar to a lot of others, that it is patchy. There are examples of good practice, but also, particularly where local authorities are managing a lot of contracts, and maybe where they have a diversified supply market, it can be difficult in terms of having the focus.

Jeremy Hughes: Can I add a comment? An additional point is the need to ensure that the standards against which providers are being measured are not just the standards within one local authority area but the standards that are applicable beyond that local authority area. Certainly the research we have done is that people are more concerned about a general level of standard than they are about localism. Of course, many providers operate across more than one area.

Dr Poulter: Thank you.
Q81 Valerie Vaz: To move the debate on slightly, all three of you said you were here earlier listening to what was said about basically releasing equity in people’s homes. You run a particular scheme, so I wondered if you could touch on the kind of things that you are doing and maybe also focus on why you are only dealing with housing and not necessarily care.

Bruce Moore: I will deal with that last point first, which relates to the discussion we have been having. We are a housing provider. We are one of the largest providers of extra care, but we do not provide the care in any of those extra care facilities. That is partly because, “Who is monitoring the quality of the care that is going out?” Our role is being another set of eyes and ears to see the quality of the care. We have intervened with the local authority and had a care provider going into one of our extra care schemes removed because we would not be able, as professionals, to articulate where that was falling down and address that.

In terms of our general housing, a lot of people will have a carer coming in and we can monitor whether they are coming four times or just once and feed back. We are a trusted source to say, “Actually, that is not going right.” Our view was that the dynamics of providing the two services are very different and, more importantly, we are a safeguard in that process. By sticking to the housing side, we can still have an interest and be an advocate for people if their care support, coming into that environment, is not as it should be.

Equity release is a fraught area. One of the best forms of equity release is moving somewhere smaller, if it is the right thing to do. Rather than taking out a loan and having all the accruing of interest and all that side of things, it is much better to move somewhere you want to live that is more suited to your needs. That is the best form of equity release that is possible out there. Most older people are home owners and most retirement housing is rented rather than home owning, so our concern is with finding a mechanism to allow that to happen, and people are not going to fall off a cliff edge, as it were, when they are making those transitions. We are trying to introduce a process whereby people can buy a property but release chunks of their equity into renting. It is like people getting on to the housing ladder can get equity by using shared ownership to get up to owning their property but almost helping that ladder going down, rather than falling off a cliff edge in that process, is what we would like to see.

Q82 Valerie Vaz: That is quite good if you have an area where perhaps the grandparents can afford livestock somewhere. But you cannot necessarily say that they are going to be able, having built up their personal relationships, and with their family, to find a property that is near these support networks, and most of them want to stay in their own home. How do we do that? How do we release that? How do we have that conversation about it? Could you describe a bit more about what you are currently planning and what you are doing?

Bruce Moore: We are a retirement housing provider so we would be providing the right sort of retirement housing that suits people’s needs. Some of that is with an estate manager— somebody to provide that sort of focal point on site.

Q83 Valerie Vaz: Do you sell their house?

Bruce Moore: No. They will sell their own house or estate agents will sell their house for them.

Q84 Valerie Vaz: Yes, but describe how it works.

Bruce Moore: Somebody moving from their family house to their house would sell their house and buy into that. We are also offering, on our previously rented estates, the opportunity to buy a property. If, having bought that property, you want to sell or find you need some of that equity you have invested in the property to do other things, you have the potential to release some equity. The issue also is that people will sell their property and have a stack of money released, or maybe quite a small amount. They have sold their property and have maybe £70,000 or something else there but cannot afford to buy, outright, a new property with that sum of money. Having the money sitting there takes them out of eligibility for lots of other services. They can invest part of it in their property, rent the balance and allow that process to migrate into more renting as they are releasing cash for their social care needs or other requirements they have in that process. It is easing the process of transition between being an owner and a renter rather than these two worlds which will never meet. We have a lot of estates which are only rented and a lot of estates which are only home owners.

Q85 Valerie Vaz: What do your members think of that?

Helena Herklots: We have done some research on equity release, seeing what people use it for. About a third of people are using it to clear debts and quite a lot of people are using it for house maintenance. There is an interest in it. The whole issue around giving people the right advice and looking at how any decisions may relate to the benefits to which they are entitled is very important, but clearly it is an area that people are interested in. If you can enable people to think through, financially, how they can stay in their own homes, equity release might be an element of that. It may be about helping them maintain their house or making some adaptations for the long term as well as releasing some income to help them stay there. The issue of moving is a key one. We know that a lot of people want to stay not necessarily absolutely in their own home but within their local community where they have their friends or networks, unless they have made a decision to move nearer family. There you get into the whole issue of housing supply. Are there smaller bungalows, flats or retirement complexes for people to move to within their local community? Asking someone to uproot and move many miles, if they do not have a network there, is very difficult. It is a key area potentially, but we should not overstate what equity release can do because sometimes people have a misguided view that their house will pay for any care they need, their pension and pay off student loans for their...
Jeremy Hughes: To build on what Heléna said, from the point of view of dementia the situation is even starker. It brings us back to the means-test threshold and Dilnot. Typically and obviously, one member of a couple with dementia might well go into nursing care and be there for a long period of time, costing up to £200,000. You have then also to support the other member of the family, or the couple, in some home of their own. There is a limit to how much you can release through an equity release scheme and ensure that you are providing the right level of support. It brings us back to the need for the Dilnot proposals.

Q86 David Tredinnick: May I come in on Valerie’s point? I find this very interesting with all these different options. All of them are good ideas, but I go back to Bruce Moore’s point about suggesting that one might move to Westmorland as an example, which I think is an extremely remote area. To go back to what Valerie was saying, the support networks of family are crucial as one gets older and if it is a housing issue, that is what we have to address. The idea that you can move 10 counties away and be happy at that age in a totally different environment is, for me, a bit of a stretch. I wondered if Mr Moore would like to elaborate on that, please.

Bruce Moore: Most people who move to our properties are moving within their local community. We operate across 600 locations.

Q87 David Tredinnick: Forgive me for interrupting, but it was your example that I am picking up on. You said, “For example, a move to Westmorland.” I am pretty certain you said that. To move to Westmorland from the south of England or even the midlands is a long way to go.

Bruce Moore: I did not mean to say any location. It is moving within your local community. I am sorry if I have given the wrong impression. I cannot remember the exact words I used.

Q88 Chair: One has a vision of one-way trains to Westmorland.

Bruce Moore: It is about moving very locally, very much keeping connected with your family, friends and other support networks. People do not move very far at all in terms of retirement housing. Very occasionally, people move across the country with children but, more often than not, they stay within a mile, or a maximum of two, of where they have previously been living.

Q89 David Tredinnick: I am sorry, but I had the visual image of snowmobiles with milk churns on the back.

Bruce Moore: Not at all. In fact, a couple of streets can make a difference. The wrong side of a main road can sever a lot of normal ties and relationships.

David Tredinnick: That is particularly so in Leicestershire and the east and west midlands.

Q90 Rosie Cooper: We have talked a lot about unmet need in the earlier session, so I would like to ask you questions about, for example, local authority charging. Lancashire county council, for example, has recently upped the charging astronomically for day centres and services like that. I believe that is quite typical. To what extent do social care charges vary across local authority boundaries and have you any examples of that? Perhaps you could describe the impact on the people who need those services.

Heléna Herklots: There is huge variation. What we have seen, particularly in the last 18 months, is the situation where a number of local authorities have removed their maximum cap on domiciliary care charges. Sometimes what people have found is that their costs as an individual have risen hugely. Someone might have had a cap of £250 a week but that has gone and they might be asked to pay £400 or £450 a week. Often, on limited incomes, that is extremely difficult. What we are hearing through our advice line, for example, is that, because of the level of charges, people are reducing what they take in terms of that formal help and are relying more on informal help. There is an example with a husband and wife where the husband was getting quite a lot of caring, but they could not afford those higher charges, so the wife started doing more and more, cutting back on the extra support. The issue there is that that gets to a breaking point—you are putting a huge burden on that carer—and probably the costs then escalate because of a sudden admission to hospital, for example, if that caring relationship breaks down. We are certainly seeing, in terms of the contact we are getting, real impact on people’s lives as a result of this. Quite often it is also hidden because people just cope. They are facing a really tough time and we might see more of the impact a little later as those sorts of crises come through much more. But there is huge variation, and whenever we have done research with older people on this, there is a consistency of people saying, “Why are these charges so different? Why is there that variation? We want much more consistency so we know what to expect to pay.”

Q91 Rosie Cooper: Can you give us any idea of—I will pick day centres because it is the one I have mentioned, but you can give any other examples you have—what the gap would be between, say, the bottom 10% and the top?

Heléna Herklots: It is difficult to say. It is probably something on which we would come back to you with a note, but there is a growing difference. I would say. Certainly, Community Care did a very good survey earlier in the year on the difference in domiciliary care charging, which gives a good indicator. With day care, sometimes it is more difficult to tell because, if voluntary organisations are running it, they are staffing it with volunteers and absorbing some of those costs. The charge to the individual may not be an indicator of the true cost.

Q92 Rosie Cooper: How do you think that impacts people who want to move from one local authority to another? I have people who have been assessed and are having a level of service, for example, in areas other than Lancashire county council who move in and the amount of hours they are given are cut
dramatically. Have you any examples of the degree of impact that that has on those people in their choices about moving and in what they receive?

Heléna Herklots: The issue about moving out of a local authority area is a relatively small part of the overall picture in terms of older people moving. With the decision to make that move, people will not think, “Are the care charges different?” It would not cross their mind, on the whole. Therefore, it could be that they are moving somewhere where they find there is more care available and it is cheaper or it could be much more expensive. We do not have enough evidence to build up a true picture of this one, but it comes back to that general point which older people feed back to us all the time about wanting consistency in what to expect, whether that is about staying in their own area or moving.

Jeremy Hughes: From our experience, it is not only about cost variation, a charging variation, but it is also about quality variation. There are enormous differences. You can go to a situation where none of the costs are met because there is a different definition and different assessment level of what is interpreted as appropriate for local authority spending, but even if things are met you can find the quality of the support and the amount of provision is very different. Certainly, as I mentioned earlier, there are people who are moving into residential care earlier than they need to because of the inadequacies of support in the community.

Q93 Chair: It is very difficult to devise an insurance product that could come close to meeting this three-dimensional chess, with its variation of quality, charges and access. How do you design an insurance product that deals with those variables?

Bruce Moore: If you are paying in the market, you are taking the local market cost. It is when it is dependent on the local authority as the gatekeeper that you are subject to these different charges. That is where a lot of the uncertainty is. By saying you have so much money or incapacity it helps that process in terms of unlocking that certainty.

Jeremy Hughes: One of the challenges we have, and it is a slightly different point but it is fundamental, is that there is not only a difference in what is available and the charging, but there is a difference in terms of the information. There is a real information deficit. Some of those issues could be addressed in terms of giving people universal access to information about good social care, even people who are likely to be self-funders because they are below the substantial or critical need. But if we could get more people diagnosed early—we know that only 40% of people with dementia get diagnosed and we have 60% of people with the disease who do not get diagnosed—and we had an assessment which helped them self-navigate through a system that they were largely going to self-fund for at least the initial years, it would be a more powerful way of supporting people well within the constraints of the financial system.

Q94 Valerie Vaz: The Law Commission now says there should be a main definition passed down to local authorities where we are seeing differences and changes of how people are assessed. What is your view on that and what are your members saying? Are they finding it much more difficult now to get past the definitions?

Jeremy Hughes: Certainly the feedback we have—and we have a report coming out shortly on personalisation and personal budgets—shows an enormous confusion because there is not that single definition. People are finding it very difficult to know what to expect. They are appealing against decisions and are getting decisions reversed. They are thinking, “How can this be, when my needs are exactly the same, where it is very self-evident that I, as a person with dementia, or I as a carer, can show what it is?” There is an example I was reading recently of somebody who has spent six months and gone through three re-assessments with a different outcome each time, thinking, “But my needs have not changed. How can this be?” There is an enormous amount of confusion and a need for that universal understanding of what quality is and what the assessment is.

Q95 Valerie Vaz: Who will assess that? Who will draw up the criteria?

Jeremy Hughes: It is back to the suggestion of there needing to be some national assessment, whether it is through NICE or through another body, which sets a standard so that we know what “good” is. Then we can measure performance against “good”. At the moment we do not know what “good” is or we do not have a universal definition of what “good” is.

Q96 Valerie Vaz: Is it getting worse for your members?

Jeremy Hughes: As the purse strings get tighter, people are finding it more difficult to get what they need. Going back to the example I gave of 15 minute visits for domiciliary care, they are finding that, even when they are assessed, what they are getting provided with is not meeting their assessment. There was an example I was reading of somebody who was given a personal budget and the local authority said, “We are giving you a personal budget because we cannot afford to support you through the local authority system. You might as well have the problem yourself.” There are examples of where it is becoming much more difficult to get what people need.

Q97 Valerie Vaz: Who are the advocates for people like your members?

Jeremy Hughes: We are, collectively, as our organisations, and Members of Parliament clearly are. Interestingly, I do not see as much evidence, and it does not come through to us, of the local authorities being the advocates as much—and certainly the elected members. Going back to the earlier discussion, there is a hope—but I do not know whether it will be a fulfilled hope—that Health and Wellbeing Boards will provide a forum where that message can come through more loudly and clearly. I am slightly sceptical about whether HealthWatch, even if it were to cover social care, will make a lot of difference because some of the people who sustain an existence in HealthWatch are the long-suffering people who have survived through all the changes since
Q98 David Tredinnick: Earlier on, you touched on early assessment and I want you to expand on that a little. It seems to me that what you are saying is, “If only we could get to people earlier there would be less of a problem anyway.” My own experience of dealing with another form of integrated healthcare, which is complementary medicine, and looking at herbal medicine, for example, is that there are a whole load of remedies out there which are available—maybe not a whole load but some specific remedies—to help people with dementia and they are not available across the country because there are not enough people to deliver them.

Jeremy Hughes: You are absolutely right. Early assessment and diagnosis is fundamental and then putting, as it were, the power in the hands of the consumer to decide what is available, working alongside charities like the Alzheimer’s Society where we can develop innovative services in the community that look at improving the support provided to people. Those can be picked up over time, sometimes through local authority funding. We have services in Wiltshire, which initially we entirely funded, called “Singing for the Brain” groups that are now spreading around the country. We funded that entirely from voluntary income initially, but the effectiveness of it in supporting people well in the community means that it is now being fully funded, in a very good example of an integrated way, by Wiltshire local authority and the NHS.

Q99 David Tredinnick: I have one other question. Do you think the role of the Public Health Officer is key in this process?

Jeremy Hughes: The Public Health Officer and Public Health England could be key. The worry is the level of resourcing that they are going to have and whether they are going to be sufficiently open to the input of expert advice and knowledge. Public health has always been the Cinderella in the system and its relocation within the provisions of the Health and Social Care Bill does not suggest to me that it is necessarily going to change. So, yes, a well-resourced, well-informed public health system could be the vehicle through which you get this support to people.

Q100 Rosie Cooper: Going off this slightly, I fear where we are going because of people’s understanding of what they are having to deal with. You described before, for example, continuing care. I know of someone who had dementia and was in the hospital, very close to death. Whiston Hospital did a grand job and the lady was a bit better. They were then assessed by the social workers for continuing care and the family were invited into a room. The social worker and somebody else asked the questions, filled up the form and then said, “Oh, dear. No. Refused.” The family questioned it and they were told, “You were in the room. You were there.” They said, “No. You had the papers. You filled up the form. We were present but that is about all.” That lady was denied continuing care. She was transferred to a nursing home and died within five days. She was not able to feed or do anything else. They are the very people—families who see this—we are trying to get to engage in the system. Are there sufficient advocates at all levels—the phase from the early days of needing social care right to the end of that when you are talking about continuing care? How do you help people through it? The family even asked whether they could FoI the form and were told, “Oh, we don’t know what that is. No chance,” because I was telling them to ask for that. It is outrageous that people are treated in such a way and are not able to engage fully.

Heléna Herklots: I agree with everything you have said. One of the challenges is that, because the system is so complex, to be an advocate you need to know a huge amount about how it works. You need to know what the legal framework is, what are people’s rights, when you can push and challenge and when you cannot. That advocacy role needs training and needs people to do that. It is something that the voluntary sector is very strong on. It is also an area for which it is incredibly difficulty for the voluntary sector to get funding on a continued basis. It is an area under threat at the moment just when, probably, it has never been more important. Certainly for local Age UKs across England, one of the biggest things they do is provide advice and seek to try and help people potentially through that advocacy route as well. It is about creating the awareness that there are organisations people can turn to who may be able to help. It is also about recognising that if advocacy is hardwired into the system it benefits everybody. It should not be a “them and us” thing—an advocate versus the statutory authorities. It benefits everyone because it brings clarity and fairness into the system. That whole area links it to Dilnot’s recommendation on information and advice. It is critically important.

Jeremy Hughes: You can get it right. There are some good examples in the National Dementia Strategy where dementia advisers have been put in place and are the trusted adviser that follows somebody through from point of diagnosis onwards. Those are good examples to look at.

Q101 Rosie Cooper: How many of those are there?

Jeremy Hughes: They are increasing. We have 30 in the initial tranche and they are meant to be rolling out. There has recently been some more funding made available from the NHS to local authorities and to health authorities to increase their numbers. It can work but we need to do more of it. The other point is an interesting parallel with children and young people. I have not been involved in that area for 20 years, but I remember when I worked for NCH many years ago the guardian ad litem, the whole support system for vulnerable young people. We do not have the same system of support for elderly people. Maybe there is something to learn from what we have in place for children and young people. Should we have that in place for vulnerable elderly people, people with dementia?

Rosie Cooper: That is a good point.

Chair: Could we move on to integration?
Q102 Dr Poulter: We talked about integration with the earlier group of people who came along to speak to us. Specifically, in respect of looking after older people and, more specifically, with dementia—and I have a couple of questions on housing later on—are there examples that you can give of where there is good integrated care in this country?

Jeremy Hughes: There are very few. There are some examples. The best examples, and the one people come across most commonly, are around end-of-life palliative care support. There are good examples of health support being brought into somebody’s own home alongside the social care support they are getting and it is providing a continuum of support without somebody being moved into hospital for their final days. There are some examples of that happening and some examples where there are combined budgets. There is the example I gave earlier of Wiltshire local authority and the health authority working together to fund some services in the community, but they are patchy. A lot of it is to do with the separation of the systems—invariably, we have two systems and two cultures—and getting people to talk together. It is the whole story about, “Why has Torbay not been replicated?” As far as I can see, the reason why Torbay has not been replicated as an integrated approach to health and social care is that chief executives do not talk to each other. They do not speak the same language. They do not get on the same wavelength. So there are not many examples.

Q103 Dr Poulter: That is a good point you have made, but is it not also the case that it is going to be difficult to get that integration of social care and NHS services to happen if the financial drivers are very different and have different financial habits?

Jeremy Hughes: Yes.

Q104 Dr Poulter: For example, hospitals are paid by payment-by-results, as we know, so preventing admissions loses the hospital money, if you see what I mean, in crude terms, which means the hospital loses some of its income. Similarly, with adult social services, the major savings will impact on the NHS but not necessarily on social services. Is this perhaps the crux of the matter, that where you have divided budgets, and almost silos in terms of both culture and budgets, that is hindering delivering the integrated service that we want?

Jeremy Hughes: Absolutely. You have hit the nail on the head. The perverse incentive is that hospitals want to fill their beds and social services cannot afford to support people, so you end up with the fact that one in four adults in hospital are people with dementia. They stay there longer than they need to because there is not the support in the community. It is partly about integrating the budgets, so you can look at one pot of money, but I do not think that works simply by, as we have seen this year, a transfer of a slug of money from the NHS into social care. It is also about following through the money. For example, with the dementia strategy, some research earlier this year showed that two-thirds of PCTs did not know what had happened to the money given to them for implementing the Dementia Strategy. There is an issue about tracking the spend even when it is within one part of the system. Coming back to the Torbay example, it is also about culture and the willingness of people to see the perspective of the service user and the patient rather than the perspective of the system.

Q105 Chair: Do the social housing people ever get invited to these integrated service discussions?

Bruce Moore: Very seldom. It is important that health and social care work together, but if you do not have the right housing environment, then we use the example of a sink. You have the hot and cold taps of health and social care but, if you do not have the plug in, it all goes down the drain. You can spend an awful lot of money without any lasting benefit unless you have the right environment, and people are going to stay in hospital beds or stay in more expensive care environments because they do not have the right home environment that links to that. All the issues you have talked about, in terms of the silos and the incentives of the funding system, apply equally in that situation as well.

Q106 Dr Poulter: I was about to come on to the point the Chairman made about the role of housing. There are onuses that are put on new housing providers in terms of disabled access and those things. This is not entirely about the traditional way we look at adult social care and the NHS, but it is crucial in terms of how houses are adapted. Is there a role for, say, the Department for Communities and Local Government to put more of an onus on local authorities to look at this issue more seriously, about how houses are adapted, houses for life and that sort of agenda, in this respect?

Bruce Moore: Absolutely. There are two elements. One is the physical adaptation of the property. With housing there is a huge amount to do with the squeezing of the eligibility, or the criteria, for the disabled facilities grants and local authorities not necessarily funding those. It is a mandatory grant, but they are not making it available as they should. There are issues there. Also, there is the role housing providers have in providing information, advocacy and other support. It is about getting the physical home environment suitable and also being the best place to make a lot of those connections, because that is where somebody lives. What do you need to enable somebody to live there effectively? Is it about where you get the access to the benefits and the access to the support provider? It is connecting all those bits up. The physical side of it is very important, but I concur with the comments that Heléna made as well about the advice element that sits alongside that.

Jeremy Hughes: It is also about using most efficiently the resources we have. If you have housing officers going into somebody’s home enabling and supporting them to make an assessment as to what the change in the environment should be to support, say, somebody with dementia, which can be as simple as having a coloured toilet seat, it can make all the difference to being able to live in your own home or not. There was a great example a few years back where the Kent Fire and Rescue Service—as do other fire brigades—had
a programme of visiting people in their own homes, particularly elderly and vulnerable people, to see if they had smoke alarms. They trained those fire brigade officers going into the homes to also make assessments about what people were eating and how well they were living. They did an initial whole assessment and it identified a lot of vulnerable people who were isolated and who were then able to be followed up, either by voluntary organisations or by the local authority.

Q107 Dr Poulter: We had the same service in Suffolk. Do you think leaving local authorities to their own devices on this is going to be sufficient to get them to act in this integrated way with housing? Or do we need to have, particularly if we are looking at Health and Wellbeing Boards run by the top-tier authority—but, obviously, housing is not the responsibility of the top-tier authority—some direction from Government in a more specific way to direct local authorities into the importance of housing in a more integrated social care system?

Bruce Moore: I want to say yes—

Q108 Dr Poulter: You can say “yes”.

Chair: Be careful what you wish for.

Bruce Moore:—but what you wish for and the reality you can see transpiring are different. You can see housing representatives on Health and Wellbeing Boards, but it is about the will locally to make sure there is good housing. To expect that health and social care will always think about the housing agenda is not realistic in terms of mandating that. It is about tackling some of the worst perverse incentives that exist in the system and articulating the benefits of working in that way rather than mandating the structures and putting people on boards.

Q109 Dr Poulter: I did not mean necessarily to mandate the structures, but do you think there needs to be a central Government driver, for there to be a local plan, for example, to deal with—

Heléna Herklots: Could I come in and say “definitely”? I can say yes on this one, Bruce. We rely so much on good leadership, do we not, on making a lot of these things work? You do need that but, particularly when you are trying to get a change through, you need some structure and some financial drivers as well. Housing is so critical to this stuff working that we need to do more than we have done in the past. We have spent 20 years trying to improve the housing circumstances of older people. We have made some progress, but older people still live in the worst housing conditions in the country. It is critical to public health, to health and social care and it is a building block. We have to find a practical way. That has to include looking at the new bodies that are coming through and saying housing needs to be part of that. It is a key player.

Jeremy Hughes: One thing that would certainly help, and probably is not within the way the system works but could easily be done, is to make the proposed forthcoming social care White Paper a co-sponsored item with DCLG. If it is only the property of the Department of Health it will not solve the issue.

Q110 Valerie Vaz: You talk about local authority housing, but there is also the other side, of people in their own homes. How are you going to get local authorities to visit people in their own homes?

Heléna Herklots: That is the critical part, because it is about how you can help people get the adaptations they need and get the insulation they need so they are not cold in winter, for example. All of those things are so critical to the health of the population that you need that local authority strategy as to how housing fits into this whole area.

Q111 Valerie Vaz: There is the philosophical argument about the state interfering, which some people do not like, and the personalisation, holding your budgets and not interfering—the state holding back. How does that all fit in together? It cannot.

Bruce Moore: There is a real struggle at the moment in terms of home improvement agencies. They are fantastic agencies in equipping older owner-occupiers to get their properties fit, suitable, adapted and all those things. They have been withering because, in effect, as budgets are squeezed, they are seen as discretionary spend and they have been lost. The consequence of the loss of the home improvements agencies—the loss of that advocacy and the case management that helps people find their way through the system to do those adaptations—means that people spend longer in the hospital bed or whatever else, costing the system much more. Those are the services which are currently being lost or ratcheted back to the bare minimum. They give people the confidence that they should do this thing and that they will be helped through the system rather than, “It is all out there if you can find it.” It is great that it is all out there and you will find it if it is, but even if it is there you need that help to unlock that potential.

Jeremy Hughes: There is also a role for the private sector and a big opportunity. You cannot go into B&Q at the moment and see products that are marked as “dementia friendly,” but surely that would be helpful. If people wanted to be able to buy something that would help them support a family member with dementia, they should be able to do that. There is a business opportunity, a market opportunity, for the private sector as well.

Chair: I want to protect one o’clock, so now we will turn to David Tredinnick.

Q112 David Tredinnick: I have a couple of quick questions about economic regulation and failure regimes. Mr Moore, what form of economic regulation is Hanover subject to at the moment, please?

Bruce Moore: We are regulated by the Tenant Services Authority—it was the Housing Corporation—and that is looking at the viability, our financial projections and our business plans. That is because there is public money invested in us.

Q113 David Tredinnick: Is there one particular organisation that takes a view of your financial viability?

Bruce Moore: The Tenant Services Authority at the moment is the regulator. That is going to pass to the
Homes and Communities Agency, but that looks at our financial standing. That is looking after the public investment that has been made in housing.

**Q114 David Tredinnick:** That is fine. More generally, what economic regulatory system does the panel think will increase public confidence?

**Heléna Herklots:** It is a system that does not only step in when there is failure but that can try and prevent it. The Southern Cross example is one that is uppermost in lots of people’s minds. We had lots of people contacting us, worried about their relatives in care homes across the country, and not only Southern Cross ones. The system will find a way of assessing financial viability, and also whether the housing model is one that could be looked at in terms of whether that can apply into the care sector as well, understanding, for example, if you need to close a care home. The University of Birmingham has said you need six months at least to do it well. That should be part of the financial viability assessment of providers.

**Q115 David Tredinnick:** Do you agree with UNISON’s call for the Government to rethink the private sector’s role in the provision of health services following the Southern Cross problem?

**Bruce Moore:** The Southern Cross problem was exceptional because of its bizarre business model and also because of its scale. Most care homes are run by one or maybe two entrepreneurs, and there are many, many providers. The Tenant Services Authority only looks at the larger housing associations because the small housing associations are too small to be on their radar. The scale of the risk is so much smaller. It is about finding a mechanism whereby you are assessing not only the quality of the service but also if there is a viability behind it in terms of its charging, its financing, and where it is funded from. If you can see it is being squeezed, you will either squeeze the quality of the care that is provided, which is the worst thing, or you will go bust. There has to be a mechanism whereby poor operators are taken out of the system and replaced. It is part of that regulatory overview, saying that if you are not making enough money something is going to go wrong.

**Q116 David Tredinnick:** What sort of failure regime would guarantee continuity of service if we have a problem in the future?

**Chair:** Coupled with that, David, is there any evidence in the Southern Cross case yet as to the scale at which individuals’ care was disrupted? There was a lot of concern but was there evidence of interrupted care?

**Heléna Herklots:** I have not seen the evidence. What it did, from our perspective, was raise huge concerns, not only with older people but with relatives. It did not matter what care home provider they were with. Part of the impact of Southern Cross was not only the uncertainty for the people who lived in those homes but also what it did to people’s views of how we care for people in this country. People who were thinking about helping their parents move into a care home were suddenly feeling even worse than before.

**Q117 Chair:** Ironically, if the result of Southern Cross was that care was not interrupted, then what we need to do is institutionalise what happened rather than change what happened.

**Heléna Herklots:** Exactly.

**Jeremy Hughes:** One of the key elements, in answer to the question, is to increase the amount of attention commissioners give to the financial viability of the people who are providing the services. That is more where we need attention than assuming that setting up something like Monitor, or extending Monitor across social care, will be the answer. Historically, commissioners have not been as attentive as they should be to the financial viability of the providers.

**Chair:** Thank you very much. I failed by three minutes, but thank you very much for your evidence.
Ev 24  Health Committee: Evidence

Tuesday 8 November 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Barbara Keeley
Dr Daniel Poulter
Mr Virendra Sharma
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Jo Webber, Deputy Policy Director, NHS Confederation, Peter Hay, President of the Association of Directors of Adult Social Services (ADASS) and Strategic Director Adults and Communities, Birmingham City Council, and Councillor David Rogers OBE, Local Government Association (LGA), gave evidence.

Q118 Chair: Good morning. Welcome to the Committee. Thank you for coming, and, in David Rogers’ case, coming back yet again. Could I ask you, briefly, to introduce yourselves and tell us where you come from, please?

Councillor David Rogers: I am Councillor David Rogers. I chair the Community Wellbeing Board of the Local Government Association.

Jo Webber: I am Jo Webber, Deputy Policy Director at the Local Government Association.

Peter Hay: I am Peter Hay, Strategic Director for Adults and Communities at Birmingham City Council and President of ADASS.

Q119 Chair: Thank you very much. I would like to begin this morning, if I may, with a question about quality in the delivery of social care services which was prompted by a piece of evidence we received a couple of weeks ago from Bruce Moore, who is the chief executive of Hanover Housing. I want to read you a quote from the evidence he gave us and ask you to react to it. He said to us:

“The standards at the moment are very low...At the moment, the standards of board and lodging, if you like—the accommodation side—are probably one of the worst in Europe in terms of the standard of residential care accommodation. Anything we can do to enhance that has to be welcomed.”

If the base proposition is true, I suppose the conclusion is true as well. But do you think the base proposition is true?

Peter Hay: We would argue very strongly that there is a need to ensure that good quality care is paramount. That is key to reform and to encouraging people, in whatever way they choose, to pay for it as well as to build the case for reform. CQC’s data, which are only about the minimum standard—they do not give you now any detail about the stretch beyond that—are clear that 70% of residential care meets those minimum requirements, and 80% of home care. That does not mean that 30% are in the gap. It means 30% are somewhere between that and their failure regimes. The trouble with our care system is that it is too diverse. There are some fantastic examples, and there has been some great work done in changing residential care—in particular, the My Home Life initiative. Equally, there are examples of considerable failure, and we have seen some of those very tangibly this year. We have to be clear and assure the bottom line, particularly around dignity and safety, as well as build great quality from there. But I do not agree that it is the worst in Europe.

Councillor David Rogers: I do not have a great deal to add to that, Chairman. Obviously, there is a range of opinions and there is a range of levels of quality. The CQC facts speak for themselves, as Peter has said. In some ways, we ought to look beyond exercises which measure it in that way and look at what might be described as “softer measures”—how people feel about the care they are getting and whether they are or are not treated with dignity in whatever setting they find themselves. That is why the Commission that has recently been set up to examine those issues is a step in the right direction and could well come up with some ways of seeking to ensure that is better in the future.

Q120 Chair: Whether the starting point is, as the Hanover Housing man said, that these standards are the worst in Europe, or whether the starting point is that there is too much variation and there are too many examples of service failure, the conclusion from either proposition is that things are not as they ought to be in terms of the quality of care delivered to people who use these services. That, presumably, is not in dispute.

Councillor David Rogers: No.

Peter Hay: No.

Q121 Chair: It is not that people are not interested. It is not that people will low quality of service delivery. What is the key issue in your mind that has gone wrong to allow that to happen and how should it be addressed?

Jo Webber: There were a range of things going on. One element of that is society’s view of elderly people and how they should be treated. Another is that a lot of residential homes are small “islands of care” and it is very easy, within a small island of care, to get adrift of standards and quality. That is one of the reasons why we have, along with the LGA and Age UK, set up our Commission to look at dignity in care. We want to know what it is that stops the best care becoming something which is adopted by everybody across the system. That is why we are doing the work now. What we want to come up with is not another example of explaining what is wrong with the system but some tangible methods by which we could encourage spread across those individual care homes.
I do not have those For older people it is £450 a week.

Peter Hay: One of the key issues here is that social care is in urgent need of reform. It needs a single coherent framework against which we set out what is important and how that is delivered. If you stick with residential care, there has been a debate about whether residential care is necessary or not. Once you begin to move to the point that it is unnecessary, you leave it alone, and the dangers of that are clear. We need a coherent framework of the values that are important, particularly about dignity, safety and quality and how those are promoted. That comes through to some of the tensions to which you have alluded. You will hear from providers that commissioners should not play a role in contract monitoring and quality assessment.

Q124 Chair: Do you mean they should simply send the money unconditionally?

Peter Hay: I did not say that, but you can. It needs that kind of counterpoint. You are absolutely right. The key issues are ensuring the involvement of both the commissioner and, increasingly, people who hold those budgets themselves in determining and assuring the level of quality so that there is constant vigilance about value for money and the quality being delivered to the standards that people expect.

Councillor David Rogers: To expand on that for a moment, if I may, it is not only the commissioning that local authorities do or the personal budgets that are being deployed in the way that has been described. There is also the growing number—tens of thousands or hundreds of thousands—of people who are making individual purchasing decisions based, sometimes, on information that could be better. Their feedback is also important to drive quality.

Chair: Thank you.

Q125 Rosie Cooper: I was almost about to be sarcastic and say, “Let me give you a clue.” Money is driving this down. Might I ask Peter and David how much your authority—Birmingham—pays per week for residential care?

Peter Hay: For older people it is £450 a week.

Councillor David Rogers: I do not have those responsibilities in the local authority.

Q126 Rosie Cooper: But do you know how much you pay?

Councillor David Rogers: It is a not dissimilar figure, but the fundamental point, which I think you are driving at, is that the current system is underfunded and has been for many years. The demand is growing and, therefore, that gap is growing. That is a case the Local Government Association, and indeed others, have been making for a long time.

Q127 Rosie Cooper: I do not know if you have done a tour of residential homes. Last year, I spent a number of months visiting them, and a more depressing and horrible experience I have never had in my life. When you get into the detailed reasons for it, the local authority is driving costs down to a figure which is below cost to the providers who, therefore, try to recoup that money from self-funders. The whole thing is so tight that there is no room for manoeuvre. Then we sit and wonder why standards are being driven down to what can be said to be probably one of the worst in Europe. I do not know what Europe is like—and better minds than mine can say whether that is true or not—but one thing is for sure: the CQC were here in front of us and said that standards were at the absolute minimum, and still we have homes failing. You acknowledge that you are paying what is a minimum and what is possibly below cost. How can you sit there and be surprised or tell us that you think this is okay and people are getting quality? They are not.

Councillor David Rogers: I have already said there are the measures the CQC looks at, but there are other measures. The best homes are firmly embedded in their local communities. You were hinting at this, Jo—that where there is contact and they are seen as part of a wider community, it is likely that the level of care delivered to individuals is better than where they are isolated. I have also said that the system as a whole is underfunded.

Q128 Rosie Cooper: Absolutely. What do you say to an old person, for example, in Liverpool where the homes are getting £420 a week, which is below a level at which providers would say they could provide a good service? What do you say to the people of Liverpool in this system?

Peter Hay: What is clear is that local authorities pay a rate they agree with their providers in that area.

Q129 Rosie Cooper: No. They tell their providers.

Peter Hay: Not all local authorities tell their providers. In Birmingham we are doing an exercise called “open book” and trying to work in a consensual manner on the costs and paying for that. We are not interested in “doing one over” on the providers. It is a shared responsibility. We are working in that “open book” way to agree a fee rate. It is not only about the fee because, clearly, occupancy rates are also important in this business and we need to understand both dynamics. I am not interested in buying poor quality care. Providers choose to enter those agreements and I want to do so on an amicable footing, a footing which recognises the proper role of residential care. I do not recognise your description of residential care as universally depressing. I can take you to care homes with a majority of council-funded placements that are far from overwhelmingly depressing.

Q130 Dr Poulter: I have two points. Jo Webber said that we have islands of care in residential care. There
may be some better examples in Birmingham, but that is certainly the view expressed. We then have the slightly utopian view that we need to have local residential homes embedded in the local community. That does happen in some places, but it certainly is not going to happen in deprived urban areas at the moment. What I am trying to drive at is: should there be a much stronger onus on local authorities to monitor the contracts that they are putting in place and ensuring that the standard of residential care is better? Certainly, it appears that local authorities may commission services—give the money—but is there the monitoring in place to make sure, at local level, which Councillor Rogers said he wants to see, that that is happening? If it is not happening, should it happen?

Peter Hay: We would want to take one slight step back. If you are in the business of providing care, it is your business to assure yourself about the front line and the quality of it. That emphasis has been lost in recent years. This is still an industry that, occasionally, says it is the responsibility of the regulator and not the provider to project quality. Reflecting, particularly, on recent events, the fact that the eye was not on the ball of quality, from the people whose business it is, has been a serious shortcoming in the system.

Fundamentally, if you choose to enter this business, we need to find ways in which the quality measures are transparent and you are working with that; then, clearly, the council, together with those who are buying their own care, have a role in that further quality assurance and checking and reporting on that, and, increasingly, in how that is communicated to those considering care, so that they are making informed decisions and can see what is happening to the quality standards being achieved.

Q131 Dr Poulter: Do councils do that at the moment across the country? Do they monitor the standard of care that is provided? Obviously, it is desirable, as Councillor Rogers has said, to make sure that the care homes are embedded in the local community where possible—and it may not be possible in some parts. Do they do that effectively at the moment?

Peter Hay: There are some areas for improvement, but essentially—

Q132 Dr Poulter: Can you explain how you do it in Birmingham? When you have given the money to the provider, how do you intervene if there is failing care? How do you monitor care in Birmingham?

Peter Hay: We monitor the contract and quality, and that ranges depending on what our judgment of quality is. For some of the providers who are struggling, we have quite intensive periods of intervention and assistance, designed to help them recover their business and quality standards.

Q133 Dr Poulter: In what sort of ways?

Peter Hay: That includes putting people on site to work through what is going on, to suggest areas for improvement and agree an action plan, through to, if we are satisfied with the level of care and quality, more infrequent review-type meetings and all the rest of it. Clearly, what we then also have is constant review of intelligence, particularly from front-line staff but also from people themselves, in order to adjust where we think people are. The final dynamic, of course, is that this is not only contracting. There has been a growing oversight of care through the viewpoint of safeguarding vulnerable adults. Sometimes that merges into quality as well because, increasingly, safeguarding is one of the tools being used. It covers a range of things from harm through to quality.

Q134 Dr Poulter: Certainly, it sounds as if you are monitoring contracts, but are you satisfied that this is a standard practice among local authorities?

Chair: Can I add to that? Where does the information come from that allows you to do what you have just been describing?

Peter Hay: The first point of good information is engaging your staff in perpetual use of it. Clearly, we are obliged, by law, to review care packages, so a review should also be intelligence and insight into how that person’s care is being received. Obviously, you also have intelligence coming from safeguarding referrals. You have intelligence from carers and relatives as well as from residents themselves. Pulling all that together gives you an overview of the care provider in your area.

Q135 Dr Poulter: But the point is that it took the Care Quality Commission to go in, from a national perspective, and flag up abuses at a local level. What I am trying to drive at is, what you people are doing on the ground to deal with these abuses and poor care. You are paying for the contracts and you are commissioning them.

Peter Hay: The vast majority of safeguarding issues are dealt with by the local authority at the local authority level. They are not discovered—

Q136 Dr Poulter: If the CQC has to go in and flag up abuses, clearly local authorities are not dealing with local safeguarding issues.

Peter Hay: No. If you look at where referrals come from, in relation to safeguarding they come from individuals and care staff and they go to the local authority. Some are spotted, but CQC is a minor player in the detection of safeguarding incidents.

Q137 Dr Poulter: The minor player has to go in and flag up the major abuses on a national scale. Do you not believe there should be a stronger role? Is that not a failure of those mechanisms and safeguards, which you are saying you have put in place, because they have not worked? It requires the CQC, which you call a minor player, to go in and flag up those abuses.

Peter Hay: I am sorry, no. I thought I disagreed with the fundamental premise. CQC does not find the majority of abuse in care homes. It comes and is reported in other ways.

Q138 Dr Poulter: But the CQC has to flag up in a very practical and public way what goes on. We have seen how the CQC deals with that. What are the mechanisms for care homes that you have, as local
authorities, across the board to pick up on this? You have not addressed the question.

Peter Hay: CQC gives you a different perspective. CQC goes in and examines the care home in relation to the whole range of standards. That can sometimes throw a different light on how a care home is providing quality. Sometimes it can confirm the view of councils in those kinds of things. Only very rarely does it find particular incidents of safeguarding. CQC is a part of that intelligence system that allows you to take a view about the quality of care being delivered in your area.

Q139 Dr Poulter: I have one more question. I am failing to follow the logic here. We have had a lot of evidence already that flags up great concerns about care. We had the quote the Chairman gave at the beginning which said that, in this country, the standards were very low and it is probably one of the worst in Europe. You disagree with that, but that was a view expressed to the Committee. We have also heard that the CQC goes in and has flagged up standards of not just very low care, but basic dignity not being presented. My concern is that local authorities are commissioning services but are not necessarily making sure that those services—and it is very clear from what the CQC have done—are of a sufficient standard. How can things be done better by local authorities to monitor contracts and to make sure that you provide that duty of care to adult social care and elderly people that you need to in a better way? There is good evidence that has not been happening.

Peter Hay: That is about the sort of mechanisms. Some councils have used quality premiums to pay for enhanced quality. It is about the risk monitoring of providers and the work you do with providers to boost their standards. It is also the work you do in a more developmental sense. In Birmingham, for example, we have a Care Development Agency, which is about the training of all staff and supporting their development to raise standards. This is, historically, an under-trained work force. It is all those kinds of things that push together to drive up standards.

Q140 Barbara Keeley: It is my experience, locally, that the standards are too diverse and clearly, as with NHS care, they can fall below minimum standards. My own experience was going to a carers’ drop-in, asking them and having them sit and recite at you which homes are any good and which are hopeless. They are the people who experience these things. You talked about islands of care in residential care and the value of being embedded in the local community. I want to raise with you the question of ownership, because we have had the issue of Southern Cross this year, and homes being sold for their property values—a casino-type mentality of passing them round the place. Can you comment on how you can develop those values with an ownership that is changing? In my local authority we had seven Southern Cross care homes, and that is a significant proportion of the ownership. It has changed now and gone from Southern Cross to a range of other providers. I fail to see, unless we can get a grasp on this ownership issue, how one can guarantee continuity of staff, care and commitment to the values that must be important in terms of being of an owner. If you are buying and selling a home only because of an appreciation in its value as bricks and mortar, it says a lot about where we have come to. Could you say what impact you think the ownership issue has had on the issue we are discussing?

Peter Hay: From the ADASS point of view, we are very clear that the focus of the business should be on the standards of quality, safety and dignity. It was very clear that, in relation to the provider that failed in Southern Cross, its focus was not always upon those issues. It was distracted or, if you like, more minded to look at the property-type issues. We want to consider the response to that. It needs a detailed and considered review of what would make a difference in relation to that. One of our starting points in this, however, is that we think providers should be prepared to be transparent in relation to quality and governance and how those things are put together. In particular, people are suggesting there is a difference between—and this is coming across from providers—those focused on the long-term investment into models of business and those looking for short-term returns. We think that transparency would allow people to choose what is important to them. Sometimes different things are important to different people, and there is nothing fundamentally wrong with the property model being used by Southern Cross. Other people use that all the time as part of business costs. The focus of the business and its transparency about its standards are key to the future.

Q141 Barbara Keeley: Following on from what you said, it seems to me that, having been involved—as other MPs have been—in talking to Southern Cross about what they are doing, there is very little control at the local authority level. That goes back to the point, just made, about what happened. Southern Cross was deciding who the new owners would be. A number of times, during discussions about that, I thought that that was not right. Here we are with many thousands of people—35,000 or whatever it is—across the country whose day-to-day living and future living is being decided on the basis of, “Do I want to own these bricks and mortar?” If you are having a review of that, it is very welcome. However, where we have been with this handover from Southern Cross happening right now is an issue that you need to keep a handle on.

Peter Hay: Yes. Since the mid-1980s we have made a decision, as a society, that there is a role for the independent and private sector in the care of older people. That has grown and changed as a business to see the emergence of big providers of the scale we now have. That means they make decisions on a business footing. That is not the role of local authorities. There is no role for local authorities in determining whose businesses they are. Our role absolutely—and it is a role in which we are not as strong as we could be—is about informing people and helping them make informed choices in relation to what they choose to take up.
Q142 Barbara Keeley: Where does the role sit, then? If you think it does not sit with local authorities, where does it sit? Is it with Ministers?

Peter Hay: There is a particular role for councils in determining whom they commission from. That is absolutely there to be determined, if you like. Part of that is also, as I have said, helping customers understand what they are buying, how they are buying it and whom they are buying it from.

Q143 Chair: Do you think there should be a “fit and proper person” test for the operator of a care home? We operate a “fit and proper person” test before you can buy a newspaper title. Should you operate the same principle for somebody who operates a care home?

Peter Hay: There are currently those kinds of tests in relation to the management of the home, and there were provisions in relation to the registered provider issue. Clearly, as I said, one of the difficulties is how you determine financial viability as being the particular issue, and how you would spot that. That is much more difficult than a particular type of test.

Chair: It was a slightly unfair kind of “curler”. I am anxious to move on. I will go to Valerie and then David, who has been waiting very patiently.

Q144 Valerie Vaz: We have other questions on Southern Cross for the other group. That model failed, so why do you think that is acceptable? It may have happened in the 1980s, but the whole economic situation has changed now. Is it not right that we should revisit that model? We are talking about “customers” when actually, we are talking about elderly people.

Peter Hay: I do not think it was acceptable that the model failed, but the responsibility of that is absolutely the responsibility of Southern Cross. If you look at the history of Southern Cross, people removed equity and value from that business on the back of other decisions. It was not an unprofitable business. They also did not have a focus on the needs of older people or people with a learning disability. The driver of the business was property and return. That created a model which, inherently, crashed and burnt. It is about the failure of that provider. We need to learn lessons from that as to what needs to be in place to spot and deal with that. Behind how that happened, it is much more complex. As I say, on the surface, that was not being detected. It is important that we have a full review.

From the point of view of local authorities, we have met our responsibilities in full and responded with reassurance and a calm transfer. The predictions of doom and gloom and older people dying in the car parks never happened. We have worked to commission the transfer of Southern Cross in a very safe, smooth way. It is absolutely imperative that we now reflect on what we have learnt from it and how we can move forward.

Q145 David Tredinnick: I now want to look at the integration of health and social care services. The first question is: what health and social care services need to be integrated, and to what end? What other local services need to be included, please?

Councillor David Rogers: Our view, in the LGA, is that this is ultimately about the wellbeing of individuals. They are going to have, as individuals, a variety of needs and a range of services that can help to meet those needs. We take a broad view of that issue. You were hinting in your question that it is not only about aspects of health care and aspects of social care. It is about all the other things that happen in a particular area or a particular community that support people’s lives, whether that is community safety, leisure, housing, transport or lifelong learning opportunities—everything that enhances somebody’s life. That is why we see a very clear role for leadership in this at the local authority level, and why we welcome the proposals for Health and Wellbeing Boards, for instance, in the Health and Social Care Bill. We see that as being the vehicle—the mechanism—for commissioning decisions or influencing commissioning decisions in the future that will help to achieve that.

Jo Webber: The issue with integration is particularly about people with multiple long-term conditions, which is a lot of the very elderly or the elderly-frail. Integration comes in many forms. It can involve integrating services within a pathway of care for an individual patient. It can be about integrating the commissioning. One of the key problems with the word “integration” now is that it is used to mean all sorts of different things to different people. If you look at personalisation and personal budgets, that is the ultimate integration of budgets, particularly where that is a personal health as well as a social care budget. The people for whom you could see the most gain are the frail elderly with a multiplicity of conditions. There, you need to have a package of care which is based on the functionality and independence of that individual and not a particular disease they may have, because they will have several of those.

Q146 David Tredinnick: Before we go to Peter Hay, if a patient, their family or provider thinks a particular route of medical treatment is appropriate, do you think that is something physicians should listen to in this area of choice the Bill is addressing?

Jo Webber: I am not quite sure of your question.

Q147 David Tredinnick: You touched on the issue of choice and I am trying to expand on that. If a patient wants to pursue a particular line of medical treatment, is that something that close attention should be given to in these reforms?

Jo Webber: Absolutely, yes. This is always going to be a balance between choice and integration. The two are not mutually exclusive. If you are looking at a pathway of care, an individual and their carers may have a series of choices to make within that pathway. The key thing, from their point of view, is that patients do not recognise the slightly artificial differences between organisations that we use in everyday parlance. For them, the most important thing is to understand what is happening to them, where they can make choices and where they can input into their own
care package across a range of things that helps to support them to be independent.

Q148 David Tredinnick: That is very helpful. Finally, Peter Hay, do you have a perspective on this?

Peter Hay: Yes. The work we have been doing is to try and move social care away from being just a set of specialist services for people of the highest possible need: to think not only of that but also work around enablement, restoration and rehabilitation of people with needs back into their homes and communities with fewer services than needed before and, indeed, an increasing offer with universal services, prevention and information. You have to think of the different types of integration needed across those three areas. That fits absolutely into Councillor Rogers’ point about the strategy and the local Health and Wellbeing Board’s role in that. Linked to that strategy, we clearly support the integration of resources with the outcomes you are trying to achieve and want to try and explore that further.

Q149 David Tredinnick: I know a lot of other Members of the Committee want to come in on this, but you would see patient choice as an important aspect of that, would you?

Peter Hay: Absolutely.

Q150 Barbara Keeley: I am interested in what evidence there is about the integration of health and social care advancing or receding. The interesting thing is that this has been a policy driver for years and yet we only find very few examples where it is working as well as it might. Given what you said about long-term conditions, I know, for instance, that the abolition of my local PCT has ceased active case management, which is an area of integration. So I have seen, locally, things affected by that. Are the changes that are happening, particularly the abolition of PCTs—the churn in the NHS—affecting things? Is this integration moving forward, staying still or receding?

Jo Webber: We have evidence of different things happening in different places, as you would expect. We did some surveying work with ADASS last year about what helped local systems to integrate. We surveyed PCT chief executives and directors of adult social services. It was about having shared visions, common directions locally, good relationships and a shared culture.

Q151 Barbara Keeley: But that is all going now. You are talking about something where half the picture is vanishing. PCTs are being abolished and people are moving.

Jo Webber: The issue is that, in a period of instability, it is always more difficult and challenging to keep those integrated services going.

Q152 Barbara Keeley: Would you say challenging or impossible?

Jo Webber: It is challenging, not impossible, because it does depend on the relationships. Not everybody is leaving from every area in the country that was there before. There are still some local teams who are committed to continuing with the integration, but it is challenging when you are moving things around and people are thinking about where their long-term career prospects are. That is a distraction from the day job of how you develop integrated structures and integrated services. It makes it more challenging. It is not impossible. In some areas of the country, the financial constraints, in particular, make it something people are looking at earlier on because they recognise there are efficiencies to be made.

Councillor David Rogers: Can I add to that? Jo, quite rightly, has said there is mixed evidence on what is happening in the current situation. Coming back to my earlier point, the way we view integration is based on the individual, starting with the service user or patient. There is enormous potential for Health and Wellbeing Boards in the future because they will include locally elected representatives and GP representatives, both of whom are close or should be close to those individuals. Therefore, they will have, in my view, the necessary thoughts in their mind—the way they go about their business—in setting the priorities and ultimately doing the commissioning to drive that process forward in the interests of the service user or patient.

Q153 Dr Wollaston: Following on from that point, I am wondering to what extent you think the proposed Health and Social Care Bill will support integrated commissioning. You have mentioned that you are very positive about the role of Health and Wellbeing Boards, but what other things, such as changes to Payment by Results, need to be put in place? What further measures do we need to support the drive towards further integration? What aspects of the Bill are holding it back?

Councillor David Rogers: I do not claim to be an expert on Payment by Results, although I realise it does have significant impact on the system as a whole. I do not want to pre-judge what you might say, Jo, but you probably know more about that specific issue than I do. As I have already said, the proposed new structures after this period of turbulence, which is understandable for the time being, do have enormous potential to drive integration. That, in my view, will be good for the individuals who, at the moment, are somewhat mystified about what health care is, what social care is and, indeed, what the other ranges of services are that might help to support their independence. The potential is there. There is a turbulent period at the moment, but we have a good deal of, in my case, positive anticipation of what is going to be possible in the future.

Jo Webber: The issue is how you bundle and unbundle elements of Payment by Results to develop something that gives you, for some patients, what will need to look like a capitated budget so that you can have a year of care. That enables you to work with partners locally on the preventive end of care as much as on dealing with some of the crisis situations that might come up. The whole point of personalised care packages is that they must be able to help you better support people in their own environment to live to their potential. There are ways of using Payment by Results, if that can be bundled up in a way that makes
Absolutely. Then you can move money back to the primary care end. That would give more flexibility to genuinely put the money back into the primary care end. If we incentivise the whole pathway of care, that’s what you’re feeling would be, if we incentivised the whole pathway of care, that would give more flexibility to genuinely put the money back to the primary care end.

Q154 Dr Wollaston: At the moment we are incentivising hospital-based care. Your feeling would be, if we incentivised the whole pathway of care, that that would give more flexibility to genuinely put the money back to the primary care end.

Jo Webber: Absolutely. Then you can move money around the pathway and there is an incentive for you to look at preventive and early interventions of care rather than waiting until there is a crisis before the patient gets care.

Q155 Dr Wollaston: Do you see it as the role of Monitor to drive this, or the NHS Commissioning Board?

Jo Webber: It is the role of the commissioners within the system to drive this. This is where areas like Health and Wellbeing Boards can come in. You can develop, locally, a pathway of care which may vary from area to area but works with the grain of the local community and the place where that patient is living.

Q156 Dr Wollaston: Do you feel hopeful that that is going to happen, that we are going to see capitation-based Payment by Results and whole pathway care?

Jo Webber: I would hope so. Payment by Results works on an episodic basis with scheduled care very well, but we need to get much more subtle about Payment by Results when it comes to dealing with people with a range of long-term conditions.

Q157 Dr Wollaston: Is there anything else you would like to add that you think would improve the system to drive better integration?

Jo Webber: Going back to the previous conversation, stability is always good for driving integration, although I know that is not within the gift of the Health Select Committee. Developing local relationships and ensuring you have a system which people have information about and can navigate their way through is going to be very important, as is bringing in other players locally, particularly housing and leisure facilities. To keep people independent, well and active you need to have that pathway included—other providers that, traditionally, you might not have thought of as delivering health and social care.

Q158 Chair: If you are going to have the kind of flexibility within the budget between health and social care, and in particular social housing, is that possible, do you think, without a single integrated budget?

Jo Webber: You have to align the budgets. I am not sure whether you need a single integrated budget, but you certainly have to align them and make it easier to pool budgets—at the moment, is not as easy as it could be—to ensure you can pool that money.

Q159 Chair: Can I put the question another way? Do you agree it would be simpler if you were operating a single budget, and that aligning separate budgets is, necessarily, more complicated?

Jo Webber: There are some fundamental issues about what is chargeable and what is not. It would require a lot of thought before you completely integrated health and social care budgets.

Q160 Chair: From the point of view of the commissioner, the result, if those issues could be addressed, would be a simpler commissioning process.

Jo Webber: It would. However—

Chair: Says he, leading the witness.

Jo Webber: The other thing to remember is that things are going to be commissioned at many different levels within the new health care system. Some elements are going to be commissioned at National Commissioning Board level and some at local level. Integrating the whole of that would be quite difficult.

Q161 David Tredinnick: One part of the puzzle that has not been mentioned is the public health officer, this new role that is recreating something that was around in the 1970s. How important do you think that role is?

Peter Hay: It comes to the crux of the issue. Jo referred to the work we did together—in an integrated way—on the conditions for integration. Clearly, over the last year, a number of those factors we identified—such as financial complexity and organisation stability—have got worse, not better. One of the key features of the new world is how you can, through the Health and Wellbeing Board, embed the joining together of the budgets—which is only the start of the work, from my own experience, and even though it finishes with it, it takes a lot of hard work to get there—as a way of doing business. Although all the evidence suggests it is relationships, trust and things like that which build integration, we have not embedded it into the way we work and the governance systems of the place. That is fundamental. Secondly, once you have your aligned budget, you need to do some fairly difficult and long-term work—not a takeover, but creating a new way—on taking the best of commissioning from both and using the best skills in both and blending them. For example, we have entirely different approaches to working with markets. Finding ways of working that out is absolutely key. Public health plays a really important role in setting the strategic direction and priorities for all of that so you know, very clearly, where you are aiming. The great hope for public health is to set that “light” as to what it is we are trying to achieve here and how we might be able to achieve it. Then you have your mechanics of joint commissioning and integration towards that strategic end.

Councillor David Rogers: Directors of Public Health have enormous knowledge and experience of population health as opposed to individuals. That is what they would be bringing; in the advice that they are able to offer, to the new structures. From my point of view, that would be extremely valuable and at least as valuable as that offered by Peter’s colleagues as Directors of Social Care and indeed Directors of Children’s Services.
Jo Webber: They also have a wealth of understanding from the evidence base for a lot of health interventions. That can be very helpful when you are looking at how you move towards early intervention.

Q162 Chair: Evidence base or lack of it.
Jo Webber: Yes.

Q163 Andrew George: I want to move on to Dilnot, but may I permit myself—for being well behaved earlier by not interrupting—to build a bridge from the earlier discussion on quality into Dilnot by this route? How sustainable do you believe the system is, looking into the future, if it is built on the back of the lowest-paid workers in the country? These workers are being asked to do work which most of us here would not be prepared to do—that is, to clean up after immobile, demented and incontinent older people—working shifts and still getting minimum pay. Is it sustainable, for this system, to continue on that basis, particularly where you are talking about quality? Staffing complements are often hardly capable of keeping pace with the pressures on them.

Councillor David Rogers: You have brought us back, as you say, to earlier elements of this discussion, and I know you then want to move on to Dilnot specifically. Fundamentally, this is about the way society values older people. In my view, that value, currently, is not at the level it should be, and all the other things we have been talking about flow from that. That is why I mentioned the Commission on dignity in care earlier. It is those dignity-type issues, which, again, you have alluded to in your question, that lie at the heart of so much of this. It is incumbent—not on those of us who are involved in current roles within the system, but much wider than that—on society as a whole to reassess the value of older people. That is not only but particularly because we have a growing proportion of older people within the population, and particularly in less urban than more urban areas. But it does play inversely. That is the context in which we are looking at all of this.

As far as Dilnot is concerned, we see this as an element of the jigsaw that needs to be put into place in order to bring about reform. We do not have Andrew Dilnot’s report, but the Law Commission’s report. Certainly, we have elements of political consensus that a way forward needs to be found. Obviously, that needs to be tested.

Q164 Andrew George: That is right. I will come back into it because the two questions—Dilnot and the one I was asking about, building on the back of the poorest paid—are about future sustainability of the care system. Knowing that the elephant in the room is that the care system is built on the back of the lowest paid we are asking to do some of the hardest work, I want to get an understanding from the three of you about whether you feel that is sustainable. Are the foundations going to crumble?

Peter Hay: The sustainability of social care has always been at question. If you go right back to the Wanless reviews, there were gaps between, if you like, the demand for care and the resources available. Dilnot himself reveals a further gap. The gap has never been disputed. The gap exists. Where social care has responded is by trying constantly to change the way it does what it does. Why we are developing systems around prevention and enablement at the moment is to try and respond to the further reduction and increasing nature of that gap due to the effects of the comprehensive spending review on local government. What we try and do is avert the collapse of social care by constantly trying to re-examine what we do in the absence of the reform and resources that we have clearly asked for for some time.

We would also want to suggest that it is time to rethink where we are on work force. Social care as an employer, in the period to 2010, grew by 7%, and I am sure you would be interested in the job growth going on in there. In particular, personal assistants—people employed directly by citizens with money—are the second biggest group of employees. There are now more people employed in personal assistant roles than there are working in social care and councils, suggesting there is something important about relationships rather than technical skills going on. We fully understand that, but there are real opportunities, in relation to considering this as a work force issue, to change some of those dynamics you have alluded to.

Andrew George: I will get in trouble with the Chairman if I do not move quickly and firmly into the area of Dilnot.

Chair: I have a very liberal view of these issues.

Q165 Andrew George: The Chairman and I respect each other, which is wonderful. Looking at Dilnot in the round, is this going to take us to the sunlit uplands? Is this going to be the sustainable future of care for the next, say, 25 years? There seems to be broad support, with a few exceptions. Do you all believe that Dilnot pretty much has the balance right and that what we need to do is move on and implement it as quickly as possible?

Councillor David Rogers: The questions that he was tasked with answering have been answered, but that is not the whole picture. The key point there is that we do not know what the Government’s response is going to be in terms of future funding—whether that is in an incremental way or in some more major way is, as yet, unclear. We are as interested in the answer to that as, no doubt, you are. The fact that the current system remains at risk, despite all the things that Peter and his colleagues are doing, illustrates the need for reform as starkly as anything else.

Q166 Andrew George: Mr Hay, your organisation felt that it did not deal with the growing funding gap. Is that right?

Peter Hay: Andrew Dilnot’s brief was to deal with the issue of people selling their homes and how they pay for care. He dealt with that brief admirably and in a way in which ADASS has welcomed. It does not, however, fit against dealing with the whole of social care. If we are going to come to that question, we need to address it, particularly from the domain of quality. At the heart of Andrew’s proposals are issues associated with trying to encourage people to use a range of financial products to save for their old age. They will not do so unless we are clear about...
guaranteeing a quality and a peace of mind that incentivises and builds on that. We do not invest in things on the basis of how broken they are.

Q167 Andrew George: In what way would you tweak it?

Peter Hay: The honest answer, at the moment, is that we do not know. We have not seen or been involved in discussions about what the resource commitments are towards social care. ADASS has been consistently clear that adult social care needs both reform and resources. As with pensions, when those things became clear it was possible to engage in a conversation about the short, medium and long-term priorities and to put those against the available resources. We would like, through the process of engagement and towards a White Paper, to begin those discussions. If you put the resource envelope against those, there is a range of things you could do to achieve all the objectives of both quality and, indeed, looking at how you might recompense people who currently sell their homes. You can achieve all those things, but we do not know, at the moment, what the social care work force is bigger than the NHS, and yet we cannot force in the NHS, with more than 6 million carers. The honest answer, at the moment, is that delayed discharges are going up. We know there is pressure on the system. We have to come to the crux of the issue—what is going to be personal responsibility in terms of funding, and what is going to be guaranteed through whatever scheme comes up to the Government? Being in a period of uncertainty is not helpful, at the moment. We need to know that something is going to happen reasonably soon, so the pressure on other parts of the system can be mitigated.

Q168 Barbara Keeley: People keep saying we need to have the debate on social care to move the question forward, yet it does not happen. As I understand it, the social care work force is bigger than the work force in the NHS, with more than 6 million carers. Then there are all the people receiving care. And yet here in the House—where we get 100,000 people pressing us to have a debate on the price of fuel—despite all the need, it seems so hard to get a debate going. Dilnot said that people do not think about it, do not plan for it and do not want to. How on earth are we going to get this going? We are not going to make a decision about billions of pounds unless there is a pressure. Is that not part of the problem that you have been tussling with for years? I certainly found, on talking to people locally in my constituency, that there is little understanding of this. People understand that the council spend money on bin collection but not that they spend it on social care, and yet that is the biggest budget. What can we do about that?

Jo Webber: Part of the issue is that people do not understand the divide between health and social care, so they do not understand the divide between what they will and will not have to pay for.

Chair: Do you understand it?

Peter Hay: No, not always. I have been clear that it is a very complex system with legislation scattered all over the place. It is an extremely complex system to understand. We are very clear that, in ADASS, we would like to see a simple, clear and modern system which is understandable. That includes at the point of entry to the system, which can include dementia or mental breakdown. We have an opportunity to raise the standard.

My counter to your position is that it is too late to understand the system when you become a carer or when you become demented. The tragedy of today’s world is that that is the point at which people start to understand it. Yes, we want a debate, but I am not sure we will get public support for this because it is so difficult to understand, as it currently is. We have an opportunity to place this differently.

Q170 Barbara Keeley: I think this is important. I understand that people who are demented, or their carers, are too tired or confused to engage in the debate, but they will have family members and friends. Here we have millions of people caught up in a system that is not working terribly well, that is causing great stress and pressure to people and has a work force larger than the NHS, and yet we cannot seem to get a debate going about it.

Councillor David Rogers: I share your frustration, and have done for a considerable period of time, that, despite the significance of the issues for individuals, for families and for professionals in various ways, it does not seem to get the public political attention that it should. We are all striving to achieve that in different ways because it is so important.

Q171 Rosie Cooper: One of the basic premises of Dilnot is that we should quantify unmet need. We have been told that one local authority has estimated that one-fifth of its existing self-funders would now qualify for free care. That would cost them something like £100 million. To what degree do you think the Dilnot proposals have taken into account regional variations in implementation costs? Also, what might the total cost be for England as a whole?

Chair: Can I ask you to couple that with this question? If we spend all the money—in answer to Rosie’s question—will that leverage in any private money? One of the key principles of Dilnot is that, if we put £1.7 billion of public money on the table, there...
is private money that is a new source of revenue for the system. Is that correct?

Councillor David Rogers: Chairman, that was what I meant when I talked earlier about bringing greater certainty. The cap proposals within his report do bring that certainty to give people a target, if you like, that they are aware of. In itself, that will help to bring a higher profile to the system as a whole. There will be a greater understanding of where that level of personal responsibility lies and that the catastrophic costs—if something goes very seriously wrong—either for a younger person or, indeed, an older person, will be met by the state. But it is not easy and, as the questioner has said, there will be regional variations in meeting the costs. I do not think those have been fully explored yet, but we need to be aware that that is the case. That is part of the ongoing debate between the report of the Commission and the Government’s response to it.

Peter Hay: The costs and how they fall is clearly something that can be modelled. They tend to fall over the longer term, but clearly they also do vary geographically. They are also difficult to model without being clear about what some of the policy context is for this. In particular, I would come back to the use of eligibility. There is a contrast between Dilnot’s recommendation about “substantial and critical levels of eligibility” and the work of the Law Commission, which suggests we need to redefine what we mean by eligibility.

To put it at its simplest, the challenge is this. There is an assumption in Dilnot that people will get to qualify at the £35,000 cap and beyond. We need to incentivise people not to get to £35,000. We need an enabling culture. It is in their interests because they keep the money, and it is in our interests—changing this demand constantly away from the top end of specialist services and doing something at these lower levels. That is where finance products come in. Can we find “win, win, wins” which help us to achieve that enabling public climate rather than an entitlement climate—to achieve savings to the individuals and a saving to the public purse? I do not think we are there yet. Clearly, the insurance industry is looking for greater certainty before making its move. We would say it is not only insurance, but a whole range of financial products, that people choose in relation to this. If they can have a range of financial products, we might be able to find things that work in that more enabling way.

Q172 Rosie Cooper: In chatting to various organisations, including insurers, they do not believe this is a market of real benefit to them or that they would get involved in now. If Dilnot is implemented, by the figures of that one local authority—a 20% increase in the number of people who would qualify for free care—how would you manage that?

Councillor David Rogers: I would rather look at a wider evidence base than one local authority—and you would understand that—but there could be unmet need in the system. The very fact that eligibility criteria are being tightened in the current system illustrates that some needs are not being met. That is also part of the case for reform. Whether the figures you are quoting are representative and would be real increases, and how those would then be met, is all part of the debate we need to have between his report and any future system.

Q173 Rosie Cooper: They are all the critical ones.

Councillor David Rogers: They are, yes.

Q174 Rosie Cooper: There are huge numbers of people with moderate needs that are not being met at all.

Councillor David Rogers: Yes. Of course, what happens at the moment—and you started off by referring to self-funders—is that there is a period of time when some people meet their own costs, they run out of money and then they become the responsibility of local authorities. It is a very complex system, both for the individuals concerned and for those who, in their professional life, have to try and manage the process.

Q175 Rosie Cooper: If that situation exists, they become the responsibility of us all, and the local authority by default, if you like, and we have to find a solution. We cannot keep driving down costs and expecting quality to go up. I know we talk a good game, and I am tired of listening to the good game, but the reality out there is not necessarily the good-game talk.

Peter Hay: What we have is a responsibility to reform this system. Behind your question sits an assumption that this would be back-loaded for those who have paid for their own care. That would have to be part of the discussions about implementation when we are clear about what the resource envelope is. Also, there is an important decision about how the state gets involved in people acquiring or consuming their resource up to the cap, and the rules for those that have already done that would need to be set with it. That is a context and a debate that can be had when we are clear about what the resource envelope is. Also, there is an important decision about how the state gets involved in people acquiring or consuming their resource up to the cap, and the rules for those that have already done that would need to be set with it. That is a context and a debate that can be had when we are clear about what the resource envelope is. Also, there is an important decision about how the state gets involved in people acquiring or consuming their resource up to the cap, and the rules for those that have already done that would need to be set with it. That is a context and a debate that can be had when we are clear about what the resource envelope is. Also, there is an important decision about how the state gets involved in people acquiring or consuming their resource up to the cap, and the rules for those that have already done that would need to be set with it.

Q176 Barbara Keeley: Can I ask an extra question on what you have said? There is paying for your care up to £35,000 or there is your family, effectively, paying for it by providing it. That seems to have been ignored.

Peter Hay: Absolutely.

Q177 Barbara Keeley: Do you agree that Dilnot should not have ignored that? There is going to be no incentive, in some ways, for a family to provide months and years of care.

Peter Hay: That is why I also referred to the tension with the Law Commission. The Law Commission are very clear. They use eligibility because we understand it, but the Law Commission virtually say, “For goodness’ sake, do not put into the new law the current eligibility because it mitigates against carers.” Those who do the most for their families and each other, sometimes at enormous stretch and strain, tend
A thought has just entered my top end? prevention because the drains always come from the not? How do we do that when we have never achieved cap. You are trying to come the other way, are you of our concerns is that you do not get this rush to the communities. It is all of that we need, not just money. We absolutely have to enhance that in some way. One

We have to find a way of building this gap financially. How we close this gap is about working with the contributions that people make—the contribution of carers and the contributions of communities. It is all of that we need, not just money. We absolutely have to enhance that in some way. One of our concerns is that you do not get this rush to the communities. It is all of that we need, not just money. We absolutely have to enhance that in some way.

Chair: I am conscious of time. Valerie wants to ask a few questions on FACS—fair access to care services—and Sarah also on personalisation. Valerie Vaz: Yes, I do, but I thought Rosie was going to lead on them.

Q178 Rosie Cooper: A thought has just entered my head. If you are self-funding then you pay, often, more than the local authority is paying. Therefore, you are usually paying more than cost to subsidise those who are coming in at a reduced local authority rate. If you hit that £35,000, or whatever that cap is, more quickly, then your safety net starts to disappear pretty quickly.

Peter Hay: Yes. We have assumed, however, that, clearly, in reaching the £35,000 new rules would have to be set for the consumption of that resource. It would change the entire funding mechanism because of the dual payment system you referred to. Again, those are all assumptions and a debate is needed about how they are taken forward.

Chair: I am conscious of time. Valerie wants to ask a few questions on FACS—fair access to care services—and Sarah also on personalisation.

Valerie Vaz: Yes, I do, but I thought Rosie was going to lead on them.

Q179 Rosie Cooper: Yes, very quickly. I have a question for Councillor Rogers. It is essentially the continuation of the point that social care should not exist solely as a welfare net for those with the severest need or limited means. If vast numbers of councils are only providing that service at that level, surely we are saying that social care is now a welfare net. We do not see social care with that very tight definition, which is the one that you are using. We see the services that local authorities provide, across a whole range of different areas, as being part of the care and support that individuals have within their communities to keep them as independent as possible, to keep them living in their homes where that is possible, and all the rest of it. So it is also about information and advice. That has been referred to several times this morning. I would not disagree that there is still room for improvement in many areas, but significant strides have been made in recent years to provide better information and advice for everybody, including those who are paying for it themselves. It is also important to realise that the context in which we are looking at this is one of striving towards integration. I know we touched on that earlier, but I do think that is the right way forward.

Q180 Rosie Cooper: Could you give me an example of anything other than advice that you provide to people with less than substantial or critical needs?

Councillor David Rogers: There are all the universal services that are available to everybody. We have touched on them already this morning, but I can repeat them. It is things like leisure services, being able to be active. That includes activities in people’s own homes or in care homes. There are services of that nature. It includes transport services, libraries and cultural activities.

Q181 Rosie Cooper: But everybody gets those.

Councillor David Rogers: Yes. That is what I am trying—

Peter Hay: Can I specifically help, as it may connect with the coming questions on FACS? As I said, we are keen to invest in a different way of doing social care, prevention, universal services, enablement and substantial care. In Birmingham this year, we are putting £4 million into telehealth care. Telehealth care is not assessed using eligibility criteria. It is assessed by your ability to make use of it. The enablement service operates at moderate, substantial and critical and, clearly, we turn to people at those levels. We have invested a lot of money in falls prevention. The eligibility for that is whether you have had a fall, not whether you meet FACS criteria. We are putting work into mental wellbeing for older people. Again, it is the depression you feel in old age, not FACS criteria. Also, we are doing work for people with a stroke, using conductive education. Again, that is determined by the stroke and by the evidence that, working together, it prevents things happening in the system. We may be able to retrieve that. That is all about trying to invest in this different model of prevention, enablement and substantial care. Quite clearly, in FACS, in the period to 2009, when resources were increasing, the number of older people being served was falling. In Birmingham, because of our demography around young people with disabilities, we were keeping up with that, but the number of older people being served was falling at greater rate than the national average. We have been trying to reverse that trend because, clearly, the FACS criteria are not working properly in a different approach, as Jo referred to, to older people in particular with long-term conditions, and to how we deal with this in a different way to avoid crisis-led responses to old age. I hope that gives you some examples of money being spent from the social care envelope. I am taking £50 million out of the budget but I am spending more on prevention now than I did in 2009 by a considerable factor.

Q182 Valerie Vaz: Before I go on to FACS, how are you measuring the outcomes for that?

Peter Hay: They are very different things. The conductive education is a full university-backed research programme with The Stroke Association. The falls prevention is more from local measurement, to track that through and to show the benefits. There is
the telehealth care thing we built, and the whole system demonstrators that are about to be published, so there are different ways. What we are trying to do—this links to the cryptic remark earlier—is to produce evidence from our practice because there is no evidence on prevention at the moment. What we are trying to do, with the explicit consent of the council—and it is not the only one doing it—is to invest in different ways of producing it and to build the evidence case. If it does not work, we will not repeat it.

Q183 Valerie Vaz: Coming on to FACS, I would like to hear from all of you what your view is on it and whether it is working. Added to that, could you give us your remarks on the portability of it? We have had evidence from people who are assessed in different ways by different authorities. How do we stop that?

Councillor David Rogers: That is certainly a possibility under the current system. As part of a package of reform, we have consistently supported an assessment that would be portable and therefore would mean the same thing wherever it was carried out. How the needs then identified might be met could vary, depending on local circumstances—the nature of the place in which the person lived. Clearly, certain types of services are more readily available in urban areas and they are perhaps not so easy to provide in very remote rural areas. There are all sorts of other comparisons you could draw. The portability of the assessment is something that we would fully support. I hope that answers the second part of your question.

Q184 Valerie Vaz: Yes. Does it still work? Do you think there should be a new role for it now?

Councillor David Rogers: That is an element of the reform we would like to see, and we have said that consistently, both when social care reform was being considered by the previous Government and, still, with the current Government.

Jo Webber: I would agree. We would also support the portability of assessment. Obviously, the way in which that assessment is carried through to services that somebody receives is going to be different depending on their own circumstances. People need certainty about the fact that they are not going to be assessed in one way in one place, and needing something completely different somewhere else—that their needs carry with them. That does not mean to say, obviously, that needs cannot change over time. Of course, they can. But that initial ability to port your current assessment across is very important.

Peter Hay: FACS is a way of rationing care. It does not necessarily mean that is the best use of resources. That is the tension we have had. It has served as a lever for the rationing, but clearly, as I have indicated, there are other ways of trying to find a more effective use of resources. For many reasons, we are clear that FACS is reaching the end of its life. But I should be very clear that it is, of course, in legal terms, the only way in which councils can control their budgets. One of the reasons it is so significant is that the law is very clear. If you are going to alter your allocation, you have to do so through the prism of FACS, so I should put that caveat in very carefully. I know that very well.

Q185 Valerie Vaz: There is a wide definition.

Peter Hay: Absolutely.

Q186 Valerie Vaz: I was wondering if it is probably better to have something like NICE guidelines—I am using NICE in the general term—where all local authorities have the same criteria. The point about FACS is that there is a lot of uncertainty. Every local authority defines the different categories in different ways. Also, on the portability issue, if you are taking it to another local authority, are they obliged to apply the same criteria? Are they obliged to help the person have that same package all the way through?

Councillor David Rogers: Peter has pointed out that that is the legal basis for this work at the moment. I agree with that, obviously, but I have also said that I recognise—it is similar, again, to Peter’s remarks—that it is perhaps not the most useful or most-likely-to-survive mechanism for the future. Therefore, we need a standard system by which people are assessed and their needs are recognised as being the same wherever they might be. How those needs are met—and I need to stress that second half of it—will depend on them and their communities.

Peter Hay: What are we looking for is tools that get you the best outcomes and the best use of public money rather than just this rationing device. That is linked to the points Councillor Rogers has made very ably about a great local strategy and how you are meeting that need. Things that help with that, rather than restrict this box, as we have been doing with needs and means, would be very helpful.

On portability, we should be clear that there are also differences between workers, as there are between councillors, as you hear from people who use the services. The guarantee people have is that they have a support plan which lasts till the next review. They never have a guarantee of the same thing for life. We need to find a very simple way, through portability, that says, “That was your plan for the next year till your next review. You can plan a move, accordingly, within that period,” and we need to trigger it towards that next review. We are making a mountain out of a molehill, if I may say so, on portability. We need to find a way through that guarantees that. It is significant for those people it affects, but I don’t think it is the way we need constantly to come back to this sole issue in reform.

Q187 Barbara Keeley: Can I take us back to the role of information in social care, as we have touched on a couple of points? As with the need for a debate, there is probably a need for a revolution in the information that is provided because that can really enable the choice and control we want to see people having. Could you comment on what progress you are seeing in that information revolution for social care?

Peter Hay: We have seen considerable progress in recent years, but we would say this is still in the nursery. It has an enormously long way to go to create the kind of informed consumers at the end of this that we were referring to. It starts with the recognition afforded to those people who self-fund and councils realising that they have a role in helping people use their own money. It is also about the role of
information and prevention—helping people make decisions much earlier—as well as information in relation to market choices and the buying of care. We are seeing some developments in there and a lot of activity going on, but we should all be clear that it has a really long way to go and it is a very serious kind of development. It must be trusted and accurate information too in order to build that credibility. It is something we would like to accelerate the development of.

Councillor David Rogers: To add to that, an aspect of it is identifying carers because, as you will know, I am sure, there are many who do not consider themselves to be in that role, whereas an outside observer would clearly see that was a role they were playing. It is about retirement planning, and planning not only for a specific date but for the needs that might arise. It is things like lifetime homes and accessibility standards within buildings. As has already been said, improvements have been made but there is still a way to go on that.

Chair: We do have to have an absolute deadline of twelve o’clock, so, Sarah, can we quickly cover personalisation?

Q188 Dr Wollaston: Can I move on to the whole subject of personalised budgets and personalisation in general? How do you respond to the charge that personalisation can undermine services for certain vulnerable groups? I am thinking, particularly in my area, of the John Parkes Unit which provides for severely handicapped children. Parents of those children are now being expected to move towards personalisation, but feel the trouble is that no private provider is going to want to take on the risk of providing the high costs. They feel that personalisation is undermining the service and would like to see block contracts. Equally, there are groups, such as those living in rural areas, who might feel disadvantaged. How would you respond to that? Is it appropriate for everybody?

Peter Hay: Clearly, the situation you referred to links to special educational needs and different related initiatives. My experience, and that of, I suppose, my colleagues with me, is in relation to the use of personalised care in adult social care need. What we have seen is the ability of people to use it; it is less about the device. It is about helping you to get the support you need in accordance with your support plan, to lever in resources from your network and those around you, and from the care market—the things that best support you to do that. We are seeing better outcomes and some efficiency. We are certainly seeing a very big movement away from the use of block contracts as people make choices accordingly. The key point in this is people getting the support they need in a way that they need it.

Q189 Dr Wollaston: Do you feel there is a case that sometimes the services are not provided because they are quite high risk to provide?

Peter Hay: We only release a personal budget when we are satisfied that the support plan in place is appropriate for the use of that budget. You absolutely have to be sure about the support plan and its adequacy before you release the money.

Councillor David Rogers: There is also a role for local authorities to encourage market development in a whole range of services. I am a councillor in East Sussex and something that council is doing—with a range of very small providers, starting with personal assistants, whom we mentioned earlier, but going up through the whole range—is encouraging more job creation and employment opportunities within that market, and therefore more choice for those who will have the budgets to deploy.

Q190 Dr Wollaston: Do you think there might be a problem in the future with some unscrupulous personal assistants undermining the system or not providing adequate care for vulnerable groups who are not in a position to let people know that that is happening?

Peter Hay: We heard a lot of those concerns when we started to introduce this. Personal budgets are now being used by one third of people using adult care, and it is very hard to think of large numbers of those kinds of instances. It is partly because it absolutely comes down to being very clear, before handing over the money, about how this plan meets the support needs, and it is also about informed people being on top of the quality and value for money they are getting. There are, of course, as there are in any system, risks and dangers but we have not seen that as a feature.

Q191 Dr Wollaston: Overall, it has been a great success in your experience.

Councillor David Rogers: Another way of answering the question you put is that trading standards within local authorities around the country have for a while been using systems involving a quality, reliability and trust procedure in relation to people like plumbers or electricians. That principle is being extended now into the sort of market development Valerie was referring to. East Sussex is doing that. There may well be other examples of that around the country.

Q192 Valerie Vaz: I have two quick questions. What happens when their personal budget money runs out?

Peter Hay: You said, “What happens when the personal budget money runs out?”

Q193 Valerie Vaz: Yes. If they get a personal budget, what happens if it runs out? Let us say they have used it on all sorts of things.

Peter Hay: The money is linked to a support plan. You cannot simply have it in a pot that gets used. Again, that has not happened that I am aware of.

Q194 Valerie Vaz: They take control of it.

Peter Hay: Yes, absolutely. You put the necessary checks in place upfront.

Q195 Valerie Vaz: We have had written evidence from Professor Ann McDonald who says that personal budgets do not work. She says it is developed around rhetoric rather than from a strong research base that
assesses outcomes for all user groups. What would you say to that?

**Peter Hay:** I would ask to show some other piece of evidence, not least the ADASS work done recently surveying 58 councils. If you look at that, the work of the National Audit Office and all those kinds of things, they point to the satisfaction of people with the use of these tools. We have some way to go. If we were to flag up the successes, it has been successful in helping us devise a different model for planning social care, thinking about preventing and enabling in particular. We are showing some—

Q196 **Valerie Vaz:** Do you think she is wrong?

**Peter Hay:** We are showing some very good outcomes in particular groups. Taking people with disabilities out of day services and into day opportunities and using personal budgets has been a major success. It is more difficult as you talk about older people with severe dementia—of course it is much more difficult—and particularly if all you are offering is a transfer of money using direct payments and all the complexity that comes with it. We still have some way to go with further development, but it is absolutely right to broaden the menu from the old fixed menu of provision to the support needed.

Q197 **Valerie Vaz:** I am conscious of the time. Thank you. What do the others think?

**Jo Webber:** Obviously, we are interested in the development of integrated personal health and care budgets. There has been some work done, particularly in mental health, as to how those work. The evidence we have is that they are welcomed by people using services. The challenge is the change in culture. Social services themselves would say it has been something they have had to live through—that change in relationship and the power dynamic between the professional and the user or their carers. That is something we are very early on the road of in health. This is a very long-term agenda. I do not think you are ever going to have anything other than a mixed economy for the foreseeable future, particularly around older frail people with carers the same age as them who may find personal budgets quite challenging, given everything else they are doing. That does not mean to say, in the long term, we might not get to a place where those integrated budgets could be the norm.

**Councillor David Rogers:** I do not want to repeat what has already been said. The evidence I have seen shows that people feel more empowered and more in control of their lives when they have a personal budget. To my mind, that is a good thing. But it does provide a challenge for professionals and, indeed, less professional staff—lower levels, I mean, not entirely unprofessional—who have been used to working in other ways in the past. It is more challenging for them than it is for those who use the personal budget.

**Chair:** We have gone beyond our deadline, but Virendra has one very quick question.

Q198 **Mr Sharma:** Before becoming a Member of Parliament I had some experience, over 10 years, of working in the social care field. I found that there was always a difficulty when the families who were the carers saw that income coming through as supplementing their own income, rather than using it. Do you not see that there still will be a conflict within the families when the income will be used for different purposes, rather than in the house?

**Peter Hay:** It is not income. It is a resource to build on the support you already have and to add to that support in accordance with suitable advice.

Q199 **Mr Sharma:** But the families see it as income.

**Peter Hay:** It is about the integrity of that support planning process, not cash on the table.

**Chair:** It is a familiar dilemma. Thank you very much. You have answered a wide range of questions very fully. Thank you very much indeed.

**Examination of Witnesses**

**Witnesses:** Mark Lobban, Director of Strategic Commissioning, Families and Social Care, Kent County Council, Helen Buckingham, Director of Whole System Commissioning and Deputy Chief Executive, NHS Kent and Medway, Sheila Bremner, Chief Executive, North Essex NHS PCT Cluster, and Jenny Owen CBE, Deputy Chief Executive & Executive Director for Adult Social Services, Essex County Council, gave evidence.

Q200 **Chair:** Good morning. I am sorry for keeping you waiting. You were probably in that session and heard that we covered quite a wide range of questions. Could I ask you to introduce yourselves and tell us where each of you comes from, please?

**Mark Lobban:** Good morning. I am Mark Lobban, Director of Strategic Commissioning for Kent County Council. I have been in post for only the past two months. For 12 years prior to that, I was the Assistant Director of Hertfordshire County Council. I am responsible for commissioning.

**Helen Buckingham:** I am Helen Buckingham. I am the director of Whole System Commissioning and Deputy Chief Executive of the Kent and Medway cluster of PCTs. I have been in the Medway system for nearly three years, but have been working across Kent only since April so, like Mark, I am a fresh pair of eyes on what is happening in Kent.

**Sheila Bremner:** Hello. I am Sheila Bremner. I am the Chief Executive of the cluster of primary care trusts in North Essex.

**Jenny Owen:** I am Jenny Owen.

**Chair:** Hello, again.

**Jenny Owen:** Hello, again. I am the Deputy Chief Executive and the Director for Adult Social Services for Essex County Council. I have been there for seven years.

**Chair:** Thank you very much. Andrew, do you want to lead straight off—first of all on Dilnot—as you need to go?
Q201 Andrew George: Yes, and my apologies for having to leave. You were all here earlier and heard the question—and therefore I will throw it at you—as to whether you believe Dilnot is the sunlit uplands. Does it provide the way forward and it is just a question of implementing it, or are you concerned, particularly in areas like yours, that it is going to mean that the public purse is going to be brought into play for a large number of people who are currently self-funders?

Mark Lobban: That is absolutely true for Kent. Obviously, it is a concern in the south-east. If you look at the demographics and the income in the south-east, it absolutely is the case.

Q202 Andrew George: In Essex, you have large numbers of self-funders, I think.

Jenny Owen: Yes. The first thing—and the most important thing—about Dilnot is that it will help people to understand what they will and will not pay for. It will set something much more clearly, which you were talking about earlier and which is absolutely apparent, that people do not plan, cannot plan and do not understand what they are going to have to pay. It will address that. It will address a cap and then the public purse will kick in. It will, therefore, cost an authority like mine more money.

What I do not know is how the Government will respond to Dilnot and how it will change a resource allocation to a place like Essex. All I can do is calculate—if, according to Dilnot, the cap comes in at that amount—how long people tend to live beyond the point at which they need that care. All that modelling I can do. What I do not know is what would be the expectation about how we would meet that within existing resources. The big issue is that it will make it more transparent and show what people pay. It will not bring, necessarily, extra money into the system. The range of questions you were asking earlier make it fairly apparent why we need extra money in the system.

Q203 Andrew George: Yes. Do you believe, in the current system, that people entirely understand that they are still meeting the hotel costs, in a residential setting? Obviously, under Dilnot those are not covered—they are not in the equation—and, therefore, people may be under the false impression that the cap will apply and, beyond that, there is no other cost.

Jenny Owen: That is right. I do not think that is clear yet. Until the Government decides whether it is going to adopt it or not, I do not think that programme of information will get out. At the moment, people are not clear what they would have to pay for, how much that would mean and, therefore, when they would reach that cap. To give you an example, people living in residential care in Essex at the moment tend not to live more than two years. How many people will therefore go over the cap? That is why you have to do the modelling.

Mark Lobban: I am hoping, as well, that it may even be a catalyst. If you think how we have had developments in housing, particularly extra care housing where you have support on site, there has not been that massive change that has been required over the years from residential to extra care. There has been great progress made in some areas, but I am hoping, with Dilnot, when you begin to look at hotel costs, that people will start to demand different models of care where they can invest in property. We might see more alternatives to residential care and have a big leap forward with extra care housing.

Q204 Andrew George: Other than seeking clarity about the Government’s response and how much they are going to put into the system going forward, do you not see any need, yourselves, within your own areas—in Kent and Essex—for any other amendments to the recommendations by Dilnot? You are relatively content.

Jenny Owen: I thought it took us a long way forward, so I would welcome them being introduced. I do not think it puts extra money in the system—that is my main beef.

Q205 Chair: Do you agree with—I think it was—Peter Hay, who said in the previous session that he felt that if there was a proper discussion, and we addressed some of the questions that Dilnot addresses and some of the quality questions, the result would be an environment where it would be more realistic to get people to plan their own affairs to meet future requirements for themselves through financial products, rather than waiting till the bill landed? Do you agree with that view?

Jenny Owen: I do agree with that view.

Q206 Chair: Thank you very much. Can we move on to the subject that you are obviously, as two teams of two, particularly well qualified to talk to us about: the extent to which the process of integration between health and social care is being developed in your localities. Do you think it is successful? What has helped it recently? What has hindered it? What stands in the way? If we could start with understanding where each of you are coming from on the integration agenda, that is the issue we would like to focus on.

Mark Lobban: As you know, I have been in post for two months now, so I have spent a considerable amount of time visiting various establishments in Kent and talking to lots of people. I have noticed an incredible wealth of innovation within Kent. One of the issues we have is that we have not consistently rolled it out across quite a large geographical area. So we do have these examples of innovation. Another
issue is that we would need to look at how we join up a strategic overview of this, particularly working with health. What I have witnessed is lots of very good personal relationships across health and social care and, where you have these very good personal relationships, innovation has flourished. What we now need to do is to step back and look at how we can have a consistent approach across the county.

Helen Buckingham: I would support what Mark is saying from my perspective, coming in across the cluster. I see some very good examples of integrated working in Kent. I have seen examples of that, in my past, as well as in other places. What I do not see in Kent right now is a structured and strategic approach to delivering better outcomes through integration. What I do see is a great deal of commitment from the new leaders in our system—I include the clinical commissioning group leaders in that—to working differently. Recognising integration of health and social care, both at the provider level around the individual patient or person who uses the services, and at the strategic commissioning level, is one of the absolute key things we have to get right to tackle the challenges we face in the future.

There is a lot of opportunity for us to do things better and a lot of willingness to do that. Where we are now is putting the structures in place around that. The discussions that Mark and I have had since coming into post, and which we have had with our colleagues, are very clear. We will get the outcomes we want to achieve only if we have the right will and the right relationships—and that means building a lot of personal relationships—and also the right governance processes around those that enable us to take decisions and put them into practice.

Q207 Chair: Integrated services means changing the way care is delivered in some very fundamental ways, does it not?

Helen Buckingham: Yes.

Q208 Chair: Do you think that good relationships, even if they mature into good relationships between institutions, are able to do the heavy lifting required to achieve integrated services rather than co-operating services?

Helen Buckingham: Not on their own. That is why we need the structures for them as well. Good relationships are a prerequisite because some of these discussions are difficult and you need to have the relationship to sustain you through the difficult conversations and the difficult implementations that we all have. They are necessary, but not sufficient in themselves.

Q209 Chair: What more is required? I am sorry, but we will come to Essex in a second. If we have something that is necessary but not what is sufficient, what more is required?

Helen Buckingham: We are putting in place a structure—and Mark might want to talk about it as well—which enables us to bring the people who make decisions in the new environment as well as in the old environment together in the right place. We are basing that on the outcomes framework for health and social care. We are focusing, all the time, on getting better outcomes for people, in this context Kent and Medway—Kent for today’s context—and doing that in a way that makes the best use of our resources. We cannot ignore, and we have not ignored today, the financial challenge around us. Our challenge—our duty—is to get the best value by, if you like, dividing outcome by cost, and the best way of using our resources mutually, again thinking about it from the point of view of the individual service user and the organisation. Organisations exist only to serve service users. They do need to exist to serve service users because we need sustainable services, but we have to focus on having organisations that can deliver personalised care. That is a big cultural shift for the organisations as well. We need the structures in place that enable us to keep having those conversations, to shift our minds as leaders and to support and empower the people on the ground who deliver all these services and think about the individuals they serve to do the jobs that they want to do.

Mark Lobban: As I said earlier, there are real examples of innovation. The plans we have at the moment for integration are exciting. The willingness to integrate services so that there are single points of access and building teams around GPs is absolutely fantastic. The challenge is how we make this consistent and roll it out across the county. I have worked in commissioning for 20 years now and this is probably the most difficult time during that period because it is down to governance. If we are very clear about governance and who is making the decisions then, for people in my position, it is very easy to commission services. Why is it so difficult? An example in Kent is that we have eight clinical commissioning groups—obviously, with Medway as well, which is unitary, there are nine clinical commissioning groups. Of course, we are also embracing localism and moving towards 12 locality boards for local government. Today my decision making—where I get my decisions—is absolutely from cabinet; tomorrow, increasingly, through 12 locality boards, working with a PCT cluster board at the moment that cannot really take decisions—and quite rightly so—without discussing and seeking agreement from eight or nine clinical commissioning groups. It is very difficult then to roll out some really good practice across such a wide area.

Q210 Chair: Can we hear how you do things differently?

Sheila Bremner: There are some similarities, obviously, in terms of the progress that has been made in Kent. You touched on some of these issues in the earlier session. There is an issue as to the definition of “integration”. Are we talking about integrated commissioning or integrated provision? In Essex, we have examples of both. There is a very clear intention about the integration agenda, and the agenda has been around for a long time, but how much progress are we making? We have something in the order of 18 or 20 different examples of integration across Essex, but I would agree with Helen that the approach to it has been ad hoc and evolutionary rather than strategic and organised. That is perhaps the bit linking to the second
part of your question about what more is needed—the bit that is missing. There is evidence, across a number of the examples of integration, that they are delivering the benefits we intended them to, in terms of patient experience, outcomes and financial benefits to the system. Going forward, perhaps the reforms offer us a number of new opportunities, through the Health and Wellbeing Board, to be very clear about the strategic intent in terms of integration. What we need, in addition to that, is very clear leadership and ownership of the responsibility for commissioning integrated services across a particular client group, for example.

There is also a cultural issue, which perhaps links back to the first point about relationships, although I think it is a bit more than that, and links to the personalisation agenda as well in terms of expecting to be able to commission—either at an individual personal level or at an organisational level—care which is joined up and not fragmented. Jenny, I do not know whether you would add to that.

**Jenny Owen:** I agree with Sheila. What I can do, which perhaps you cannot from Kent, is give an historical perspective, having been there seven years with at least three NHS changes in that time. I have to say that it does not help. You asked earlier on, “Is it impossible?” It is, almost. When I came to Essex in 2004 we had 11 PCTs all wanting to make their own arrangements because they were accountable bodies. One of those was a care trust in the centre of Essex, so we could do some comparisons. It was quite useful to be able to monitor the outcomes that they were able to achieve for older people versus the other areas. The outcomes were good—financial control was not quite as good, but the outcomes were good. But then that changed down to five PCTs, and five PCTs that were commissioning bodies. The care trust was a provider organisation and did not survive the change into the commissioning PCTs. We are now down to two clusters with seven GP clinical commissioning groups—potentially seven, as it has not quite landed yet, but about seven—also going down to a lot more local arrangements around locality boards.

What does not help is changing the system. You can get good integrated working but it almost always gets unstitched. It does not survive. Coterminality would be brilliant. In places as big as Essex and Kent, you have to be realistic that that is not likely, but boundaries are important, as is, if you have to work across boundaries, being able to get some principles about what can be consistent. When we started working seven years ago on trying to get a single assessment—I do not know if any of you remember the importance of single assessment across health and social care; I know the Chair does—it was difficult in Essex because we had 11 PCTs. I needed, for the county, one assessment system, but the 11 PCTs wanted different assessment systems. I could not work on one IT system to do that.

**Q212 Rosie Cooper:** Jenny, you talked about Health and Wellbeing Boards but they do not have decision-making powers. Sheila, I think you talked about strategic intent. Mark described a chaotic proliferation of potential decision-making bodies, which is reflected in most of your comments. How do you see that helping you and how does that impact on your ability to have an integrated care agenda from April that really starts to motor and to make a difference to the people who depend on you?

**Jenny Owen:** I am going to give it a good shot. It is better than things we have had in the past. I have been around long enough to remember joint planning arrangements and joint frameworks and so on. We have been operating in shadow form for about a year but we have not been able to bring on the clinical commissioning groups because they did not exist. They had not formed their boundaries. We now have the representatives of the clinical commissioning groups on the Health and Wellbeing Board and we have had a development day. Basically, you are right. We do not have a statutory power to enforce. What
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we do have, though, is an opportunity for that body, which is an executive body of the council, and is going to make decisions for the council, to build partnerships and the understanding, based on a good assessment of the need of our communities in Essex, of why we would have these joint strategic priorities—

Q213 Rosie Cooper: Could I ask you a question?  
Jenny Owen: I want to finish the sentence. It is in that agreement about the priorities that we will find a way forward.

Q214 Rosie Cooper: You talked about having seven commissioning groups.  
Jenny Owen: About that many.

Q215 Rosie Cooper: How many of them were represented at that development day?  
Jenny Owen: Four or five. It was five, because two have not settled yet.  
Helen Buckingham: Obviously, we are going through a similar process in Kent and all our CCGs are engaged in that process.

Q216 Rosie Cooper: They were all there.  
Helen Buckingham: They were all there. They are all at a different stage of development but they were all there at the table.  
Mark Lobban: The point I was making was that the transition is very difficult, so it is seeking that clarity. I am very happy that we will have 12 locality boards because Kent is a huge area. I am very happy that we have the number of clinical commissioning groups we do. It would be great if they were coterminous, but we have to deal with that. The problem I have, of course, is the transition. At the moment, it is the distinction between when you go to cabinet and when you go to locality boards and we are thinking hard about what can be devolved to the locality boards. Of course, we work very closely with the cluster board and their relationship is developing with the clinical commissioning groups. That is the environment we are in at the moment.

Q217 Rosie Cooper: When you say “what can be devolved to the locality board,” can you explain to me what you mean?  
Mark Lobban: Yes. This is the localism agenda. My decision making, at the moment, goes via our county-wide cabinet. The cabinet will decide what powers it wishes to devolve. Kent has set up 12 locality boards, with district and borough council members—I think there are five in place at the moment—and the decision needs to be made. It is a bit like the fire service, where you have a county-wide—

Q218 Rosie Cooper: Do they have the powers yet?  
Mark Lobban: No, they do not but, of course, we actively work with them.

Q219 Dr Poulter: I have a couple of questions. Helen made the point that, at the moment, although there may be some good examples of where things work individually on the ground in some areas, there is nothing overall that is strategic or structured in place, and there is a hope that the Health and Wellbeing Boards would be useful in helping to provide some structure in that respect. In terms of getting integration of services, it is not only about structures, necessarily, is it? It is also about how the services are reconfigured in an effective way on the ground. Would you say that the primary driver for service reconfiguration is often a financial driver and that, if we want to get proper integration, there needs to be a financial driver that assists with integration because relying on loose relationships has not necessarily been good enough in the past and will not necessarily be good enough in the future?  
Helen Buckingham: That is an interesting one, and a very interesting one as we see GPs taking over the leadership role. We cannot park the financial issues. They are very real. There is a real risk of changes being proposed which people assume are financially driven when the drive is about better outcomes. Thinking about some of the work we are doing in Kent at the moment, we have done work in our hospitals, so far in West Kent and spreading out across the whole patch, looking at what happens when somebody is in hospital. Is every day of their care in hospital an active day of care? No, it is not. Why would that surprise us? We know it is not. Why is it not an active day of care? A lot of it is about waiting for the next bit of the system to work again. Why would that surprise us? Seeing the response of the clinicians to that work has been fascinating. They want to fix that because it is the right thing for the patient. It is the right thing to get the people who use services in the right place to get the best outcomes for their care. It will have a financial benefit because of the number of days which, in a sense, are being wasted, and that will help the whole system, but the driver is about better care and outcomes for the individual. There is a real challenge for the clinical and managerial partnership, as we move forward, in linking outcomes and value for money in a much stronger way than we have done in the past.

Q220 Dr Poulter: You mentioned “value for money” there, which is the issue. The concern is, if we talk about, for example, preventing people inappropriately being admitted to hospital and the costs of that, say, for the longer stays associated with dementia, there is a human issue and there is a financial issue. It is very expensive and people are presenting in crisis because they are not necessarily properly supported in the community. Having structures in place is one thing, but, at the moment, you have separate budgets. Would you say that making those budgets work better together, or integrating those budgets, would be a very effective way of making integration happen in reality?  
Helen Buckingham: This is a personal view—and others may want to comment—but we always have to couple the governance arrangements, whether that is pooled budgets or whatever else, with the cultural and relationship shift. One on its own will not deliver the change that we need. We can put whatever structures we like in place. I have worked in places which have had good joint commissioning with good outcomes
and places that have had weaker, shall I say, joint commissioning and we have not had the good outcomes. The structure has been there but that has not been enough to deliver the change. In other places, the relationships have been there, but that has not been enough to deliver the change. It is bringing the two together that gets the change we need. It is about making sure the person on the ground—who is, in a sense, pulling the person who uses services through the system—feels they are able to do that and can challenge when the system is not working so that they are empowered at the individual level as well as us, as leaders, challenging each other about the way our organisations work together.

**Sheila Bremner:** If you are clear that there are some aims in common and there are pots of money associated with delivering those aims, it makes a lot of sense to put them together. It also makes a lot of sense to put the leadership for the delivery of those objectives and the safeguarding of the money together in one place as well. I think it makes a lot of sense. With all of these things, I do not think it is an “either/or”—one works and one does not. As Helen said, there are examples—I have worked with pooled budgets—where they have worked well and not quite so well. I do not think it is necessarily the structural change. There is the leadership issue, the cultural issue and so on. But I can see that it makes sense to say, “Okay, let us put the money in one place and be clear about what the outcomes are.”

**Q221 Dr Poulter:** On that particular point, there are, as I say, areas where there is good leadership and good relationships between health and social care, but there is great variability. It is patchy even within different local authority areas. In bringing the budgets together, would that be an effective way of reducing the variability and having it as a crude mechanism to help support this integration we have been talking about? I am not suggesting necessarily a complete budget fusion, but would some way of doing that be a good facilitative measure?

**Sheila Bremner:** It could help. In view of the variability, it will help and be much more successful in some places than in others. It is a bit like asking whether we need to have organisational change to integrate services at the provider level. You need to put people into the same organisation and have them managed in the same place. Sometimes you do and it helps; other times not. As well as putting the money together in one place, what might help is clarity about leadership and responsibility for delivering an integration agenda. At the moment, it can be spread across a number of organisations and relies on, in some respects, the good relationships, the goodwill and the intention that we have talked about. Being clear about the leadership and the ownership of the responsibility for delivering agendas is as important as putting the money together in one place.

**Helen Buckingham:** So are the measures of success, how we hold each other to account for what we deliver, and how we know whether we are succeeding or not, as the case may be.

**Jenny Owen:** I will pick up on that point. There are three points I wanted to make that pose difficulties with pooling budgets—not aligning necessarily, but pooling them—and bringing them together in that way. The first is that you have to work out who is bearing the cost and where the benefit comes. We know that, often, where you make joint commissioning decisions—and I will give you the examples of reablement, hospital at home and virtual wards—they absolutely help demand management and the NHS. They cost social care. That has to be understood—your point, that you know what you are measuring—so you are measuring those outcomes, what you are putting in and where you get the benefit. To be able to get agreement about where that benefit share is requires quite a sophisticated level of partnership working.

**Q222 Chair:** If there is a pooled budget, there probably is not a need for a benefit share, is there?

**Jenny Owen:** It depends on who is putting what proportion of the budget into the pool.

**Q223 Chair:** If the pooled budget is for the services for a particular group of people and you invest in preventative early-stage activity, the same budget receives the benefit of those individuals not needing—

**Jenny Owen:** The point I was making was that it might not meet all the social care needs. You might need to still pick up those points from the budget. That is why you have to be clear what you are putting in, what outcomes it would achieve and who is putting the proportion in—where the benefit comes from. That was the point I wanted to make.

**Helen Buckingham:** If we move to a pooled budget arrangement—and I have worked with pooled budgets and they can add real value—I am still accountable to the taxpayers of Kent for agreeing that a pooled budget arrangement is the best way to spend the money they are giving me to get outcomes for them. I have to be clear that there is a benefit to that pooled budget arrangement for health services as well as to the individuals who receive it.

**Jenny Owen:** The second point I wanted to make, to go back, was that when you move down to the level of significant numbers of people having personal budgets, as in the cash personal budgets, you then have less money to pay with in your commissioning budgets. There is going to be a different alignment between the amount the strategic commissioner has for commissioning for the numbers of people if a third of it has already gone on personal budgets. That is clear.

The third area is that we are just now getting to the point of clinical commissioning groups having budgets and setting budgets to meet the needs of their population. There are very different levels of discussion from, at one end of the spectrum, the quite sophisticated “What can we jointly commission?” to “I do not really understand how you are going to work social care.” It is that different. I am not quite sure that the clinical commissioning groups will be ready to think about pooling budgets for a while.

**Q224 Dr Wollaston:** Can we move on from that to talking further about personalisation and the negative impact it is having? Helen, could you comment on
whether you are going to find it more difficult in the future to commission services if some of the money has already been taken out and handed to people in the form of personal budgets?

Helen Buckingham: I think it is more difficult. That does not make it wrong. It is more challenging and it is challenging to the whole system. It is challenging to us, as commissioners, and it is challenging to providers. The response to some of the discussion you had in the first session—I think it was a question you raised—about the issue of very high-cost care and the risk to suppliers was quite interesting. As a provider, you can work with—and I would expect our providers to work with—people as individuals to make sure that they are delivering a package of care that is appropriate to their needs as a person, not a one-size-fits-all approach. You can do that without necessarily holding a personal health budget. The more people who do hold personal health budgets, the more difficult it is, as Jenny and Sheila say, to commission strategically by wave big pots of money around and, also, the more important it is for us to be strategic leaders of the system and to develop our markets in a more sophisticated way to enable providers to respond to that different challenge. So, yes, I do think it is more difficult but, if we are going to focus on the right outcomes for the individual and we are going to use resources in a better way, that is the way we have to go. The exciting conversations we need to be having with people who use our services is how those who are in receipt of direct payments or personal budgets from social care and, in the future, personal health budgets, at a personal level, link those two. We are a pilot area for personal health budgets and that is one of the conversations we are starting to have.

Q225 Dr Wollaston: It strikes me it is going to be incredibly complex. Is your role going to be guiding other suppliers as to what kinds of facilities they might want to look at providing and guiding your clients in how to use them?

Helen Buckingham: There will be different roles at different levels. There will be, if you like, tactical roles, which are at that level with suppliers and providers. But I hope, and this is a bit of the ambiguity at the moment, that somebody, somewhere in the new systems—and the Health and Wellbeing Boards should be well placed to do this—will also have that strategic oversight of what this means for the whole match of supply and need, in our case across Kent and Medway: what is happening to the population in Kent, so that we know what is happening to our populations of older people and young people; and what that is likely to mean in terms of the types of services and market we are going to need to have in the future.

Q226 Chair: Even if we got into a world where personal health budgets constituted, let us say, 20% of your budgets—and we are light years away from that, at the moment—it would still give you 80% of the budget. You are not without a few tools if you have 80% of the spend in your hands.

Jenny Owen: If you think about the social care spend, we have lots of experience of this because it puts people in the same sort of position as self-funders. They have the money to spend but they still need the things to buy. The only point I was making—and it was not a negative one about personalised budgets at all—was simply that pooled budgets might not be the only thing we need to think about. That was the point I was making.

Q227 Valerie Vaz: I asked the witnesses we had earlier about Professor Ann McDonald’s view on personalisation. I would like to gauge what you all think about it.

Mark Lobban: I am also a member of the National Market Development Forum and we often have discussions about personalisation. We quite quickly find out that someone is talking about it from the perspective of, say, someone with a learning disability, while someone else is talking about it from the perspective of an older person. That is an important distinction.

If I focus on older people, for instance, one of the issues we have, particularly if we are looking at providing home care or domiciliary care, is that sometimes there is a very narrow description of personalisation that is limited to this beauty contest, if you like, between providers. From work that I have done in the past, when we ask older people what they want, it is not necessarily to choose the provider that comes through their door. They want to make sure that they are from a trusted source; they want to know the name of the person that comes into their house; they want to be able to get up when they want to and go to bed when they want to; and they want be treated with dignity and respect in their own home.

The issue about personalisation needs to be much more sophisticated. I was interested in your point earlier about block contracts. The days of block contracts have gone, but I still absolutely think that there is something about how we work with providers that have volume. For instance, in Kent, no one provider has any more than 10% of the market share in domiciliary care, and there is a potential different relationship with someone that has 600 or 700 users than a provider that has tens of users. What I need to do, as a commissioner, is to be saying to these providers, “How do you provide flexible responsive services, because you have the volume?” One of the ways we could develop that is through technology, creating a marketplace where people can, Amazon-style, rate the performance of providers.

Our role, as a local authority, is to give people good advice and information so they can make informed choices. Yes, you can take a direct payment. You can take the money and arrange your own care for a personal assistant. What does that mean? You get complete control over the resource but what happens when that person is sick or goes on holiday? What back-up do you have? Alternatively, we can take this money and broker the relationship between you and, maybe, what we might call a key strategic partner because they have this volume. They can hold on to that resource and work with the individual as to how they can care delivered flexibly. The only way they can do that is if they have sufficient volume. So there is still, for older people and personalisation, the
relationship between volume and being able to deliver services flexibly. It is much more modern than your block contracts.

Q228 Valerie Vaz: Yes, but I am getting this picture of Aunty Mabel, aged 75, sitting on a computer buying her care and she is sick and ill. How is she managing that?

Mark Lobban: This is the point. I do not think older people necessarily wish to choose. Aunty Mabel does not necessarily want to choose her provider. Something that annoys me, and it happens in all local authorities, is that markets have often become fragmented. It is not down to the choice of the individual receiving care, but the way in which we purchase care. It is the misinterpretation of what “personalisation” is. For instance, social workers in some local authorities may be selecting various providers. How much is that down to the choice of the individual or a misinterpretation of what personalisation is? At the moment, I do not think older people are choosing their domiciliary providers because they do not want to, but social workers and people arranging services are. There is a way in which, if you sit down and talk to individuals, you can say, “This is the quality of the service. This is the service that this particular provider offers. They provide care to some of your neighbours and they do provide a flexible service. That is one of your options. Another option is you could take the direct payment.”

Q229 Valerie Vaz: Who is doing the talking? Is it someone at the local authority?

Mark Lobban: Absolutely. This comes back to who is assessing need and who is working with the individual to work out what options are available.

Q230 Valerie Vaz: So you still need people to do that.

Mark Lobban: I think, also, if you have this approach where you look at what personalisation truly is—and we are looking at flexible services—it is about the local authority also letting go a bit. We need to trust their providers, and there is something about trusted assessors. Providers that have earned the trust and can demonstrate the quality they provide should be given more flexibility to work with the individual to adjust packages of care. Still, today, we have too many examples where it is “time and task” and a provider has to phone social services so that a package can be reduced. Then there is a delay in someone coming out and reassessing and, at that time, the person does not even need that level of care. We have to have a new relationship with the individual but also the organisations that are providing that care.

Q231 Rosie Cooper: Could you describe how you would monitor that—how you would gain assurance?

Mark Lobban: I need to be clear. We need a healthy marketplace because it is not only about us commissioning care on behalf of social services, but about the private market as well. We need to embrace the diverse market. When it comes to the issues that I have mentioned about providing care flexibly, if you have key strategic partners, for instance, that is when you can sit providers round the table and say, “What are you doing to provide care flexibly?” I have 100 commissioning staff at the moment and we monitor care. We go to care homes and monitor care home provision. It would not be any different than what we do now. Also, there are other things we need to look at. We need to look at the wider community and at peer monitoring, if you like, of good friends and neighbours. How do we incentivise people in the community also to pop in and be the good neighbour and perform a monitoring role? There are lots of things we can do around that.

Helen Buckingham: I would like to come back on the 80:20 business—20% of budgets for personally held budgets and 80% outside that. If we get it right, that 20% in personal health budgets could have a profound impact on a large proportion of the other 80%. Except for the most specialist services, most of what we spend our money on is pretty normal run-of-the-mill, happens every day, acute care and community care. The more we can support people to take responsibility and be supported in taking responsibility for their own care around their long-term conditions, so this is the frail elderly people, those with dementia, children with disabilities—I do not mean abandon them to make all their decisions themselves; I do mean support them in their own care—the greater impact we will have on less desirable use of that expensive acute sector. Getting personalisation right is critical to every bit of the system, not only the services used directly by somebody with a personal budget.

Q232 Dr Wollaston: What happens if patients decide, genuinely, that they would rather give that money to their partner to be their carer and not use outside services at all? Would they have the flexibility to do that?

Helen Buckingham: It is the same dilemma that the local authorities have gone through with direct payments, is it not? We need the right governance arrangements that ensure that our money is used in a way that delivers better outcomes for the individual, and that includes experience, but in a way that protects them as well. There are safeguarding issues to take into account and there are—it depends on the needs of the individual—quality, experience and qualifications issues to take into account. I would hesitate to rule anything out, as I never say “never”, but there would be a lot of things you would have to look at carefully before you say yes, you would do that.

Q233 Dr Wollaston: So possibly yes, but there is a general rule—

Helen Buckingham: You need a framework.

Q234 Chair: There is a tension here, is there not, that underlies this whole personalisation agenda, which I do not think has surfaced as much as it needs to? The further you go down the road, whether or not it is social care—it is true in health care as well, but stick with social care for a second—if believing that each individual’s care can be identified precisely and then converted into a sum of money, the further you get to
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a position where you are looking at an individual and saying, “You fall into square X71 of this matrix,” and you are back to where we started. Before we had the Community Care Act 1993, this was all done through the social security system. How do you square off these two conflicting pressures?

**Jenny Owen:** I agree. It takes you to an entitlement that is more like a benefits system: if you have that type of need, you have that type of requirement to meet that need. The advantages of that, of course, are that you do not have to put so much of the infrastructure resources into the assessment type—

**Q235 Chair:** It is worth reminding ourselves why we moved away from it. We thought the costs were running away from us.

**Jenny Owen:** The costs were running away and it became the responsibility of the local authority, and then we had FACS, that gate-keeper. But now what we have is all the questions you were asking about portability and whether you can have a consistent system. That is the tension that you are describing.

As to personal budgets—and I wanted to answer your question, if that is okay—in Essex we have about 11,500 people on personal budgets. That is about 80% of those people eligible for personal budgets. Only about 20% of those take the cash. The others are on the managed service. When you look across, it is not untypical that a large proportion of people are still on a personal budget but it is a managed service, commissioned for them.

When we started on the journey of going into personal budgets, we commissioned a three-year evaluation to look at the experience of people as they went on to the system. We have had our second report and, basically, the messages are that people are really satisfied with the outcomes. It gives them a lot more flexibility and the ability to have a service that is responsive to them, which is a lot of what the complaints are about, particularly with older people looking for home care. Often the complaint is around not being able to get that from a managed service. They needed more very skilled people to help them with the support planning and brokerage. What we find is that many, many more people who have their support arrangements through the coalition go for the cash payments. It is about confidence.

We also put some resource into somebody working around personal budgets—personalisation—for people with dementia. What she concluded in her work was that, for people with dementia, personalisation is absolutely critical because it has to be very personal around the needs of that person and the progression of their disease. It absolutely can be the most important way of organising the care and support for someone. What tended to happen was that people who were working in the social care system—the social workers and the assessors—were not confident of doing it. They felt there was too much of a risk and, often, they did not see it as an opportunity or an option. Much of the work that we did was to try to show how it was working with examples of where it had been very positive. The Alzheimer’s Society is about to publish a report very much along these lines. It is not right for everyone but it is right for quite a few people. There are ways in which you need to support people through the process.

**Chair:** Very good.

**Q236 Dr Wollaston:** Do most people—that 80%—opt to have it managed by yourselves because they do not want to be employers, themselves, directly?

**Jenny Owen:** There is a whole range of reasons. In my experience—and this was a point you made earlier—when people are in crisis and needing care and support, it is not the best time to say, “Do you want a personal budget?” You need to be able to stabilise the situation, to work with the family and to think about the future arrangements. Then, when you have something in place that manages that particular crisis or difficulty, over time, you can start to talk about what is a better range of options for that person.

**Q237 Dr Wollaston:** So they gradually move on.

**Jenny Owen:** Yes. The worst possible time to give people a whole load of responsibility is when they are in the middle of a crisis. That is why reablement, doing something and then coming to a view about what service is needed, and how and when it should it be provided, is best. It is much better to do it after you have had a period of reablement.

**Q238 Rosie Cooper:** Would the managed care be done by the local authority or a voluntary agency?

**Jenny Owen:** It could be either. It is a commissioned service. It could be commissioned from the voluntary sector, the independent sector or the local authority. In the local authority in Essex we do not provide many direct services. But we have a very strong organisation of disabled people, the Essex Coalition of Disabled People, and we have contracts with them to do support planning and brokerage. What we find is that many, many more people who have their support arrangements through the coalition go for the cash payments. It is about confidence.

**Q239 Rosie Cooper:** May I quickly ask you a couple of questions about a situation where people with moderate care and support needs in Kent receive local authority funding, but people in Essex do not, and how, when we have almost a consistency of criteria, we get to that?

**Mark Lobban:** We do have moderate criteria. Obviously, as I say, I have been there two months and I have moved from Hertfordshire, where the criteria were substantial and critical. Does it make a difference? I am not sure if it does. It comes back to some of the earlier conversation about “depending on how much you invest in preventative services.” When I say “preventative services,” I mean services put in place to prevent people meeting the criteria and that threshold. I agree with one of the earlier panel members that social care is much wider now than just the services we provide and the criteria. We have the greatest incentive to provide other services to stop...
people meeting our criteria because it is far more expensive when they do hit that threshold than before.

Q240 Rosie Cooper: Is your definition, or your criteria, the same across—
Mark Lobban: Ours is moderate.
Jenny Owen: The FACS criteria are set by the politicians who look at the amount of money they want to spend on eligible needs and make that decision.

Q241 Rosie Cooper: You are talking about local politicians—councillors.
Jenny Owen: Local politicians—councillors in Kent and councillors in Essex—made those decisions based on what they had in their budget at that particular time.

Q242 Chair: Then you classify the service users into the categories where they can be funded.
Jenny Owen: As you know, it is a gate-keeping exercise and there is an attempt at objectivity. It is jolly difficult. I always found it jolly difficult as a social worker. However, as to Mark’s point about the correlation of total spend on people in a community and their FACS criteria, if you did a study of that, you would find it is not necessarily a strong correlation. For example—I do not know if you remember, and I am afraid I cannot remember the name—the authority that went to critical only a couple of years ago showed that they still spent a significant amount of money, but on people who did not have to go through the FACS criteria. They spent a lot of money in the community and on voluntary organisation spend. We have a range of services in Essex, as they will have in Kent, that support people who do not have to go through the eligibility criteria, and there is a significant spend on those.

Q243 Rosie Cooper: Do you track the people who have not qualified for support from your local authority? In other words, is this real?
Jenny Owen: We do not track.

Q244 Chair: What I think you are agreeing with is what Peter Hays said—I wanted to bring in this quote, which was not cited earlier. Julie Jones from SCIE told us previously that the fair access to the care system is “coming to the end of its useful time.” I noticed Peter used almost exactly the same words. Is that, essentially, what you are saying?
Jenny Owen: It is, absolutely. It was a way of gate keeping resource and it is not particularly helpful.
Chair: That answers the question. We have run out of time. Thank you very much indeed for coming and sharing your experience with us.
Tuesday 22 November 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Barbara Keeley
Grahame M Morris
Mr Virendra Sharma
Chris Skidmore
David Tredinnick
Valerie Vaz

Examination of Witnesses

Witnesses: Frances Patterson QC, Commissioner for Public Law, Richard Percival, Team Manager of the Public Law Team, and Tim Spencer-Lane, Lawyer, Public Law Team, Law Commission, gave evidence.

Q245 Chair: Good morning. Thank you for coming. Judging by our conversation at the pre-meeting, this is likely to be a very interesting session and I look forward to it. Could you begin by introducing yourselves, please, so we know exactly who we are talking to?
Frances Patterson: Certainly. I am Frances Patterson. I am the Public Law Commissioner for England and Wales. I head up the team which has responsibility for the adult social care project and the report.
Richard Percival: I am Richard Percival. I am the team manager of Frances’ team.
Tim Spencer-Lane: I am Tim Spencer-Lane. I was the lawyer from the Law Commission assigned to the project.

Q246 Chair: Thank you. I want to begin by standing back from your recommendations and asking about the policy context in which they are made. You make it clear that the role of the Law Commission is to produce recommendations about the legal structure for the delivery of policy determined by somebody else, rather than seek to determine policy yourselves. It seems to me that policy in the field of social care is unclear as to whether we are seeking to deliver a package of personalised care determined by an individual’s circumstances or a cash sum determined by an individual’s circumstances. If policy on that very fundamental point is unclear, how easy did you find it to make a set of recommendations about the legal structure to deliver such an unclear policy?
Frances Patterson: In both the consultation paper and the final report, we make precisely that point. There is a difficulty in drawing a clear boundary between what is policy and what is law reform. We acknowledge it is a difficult area. Having said that, our remit was to provide a legal framework—to distil, if you like, from the current legal landscape, a clear and, we hope, simple and modern framework—that would enable policy directions, whichever direction they may evolve, to lock into. In fact, we say it is “policy neutral”. That is how we tried to derive the legal framework. That is not to say we did not have any regard to the policy itself—clearly, we have had to have regard to that—but we have sought to provide a robust framework that will be future proof for a period of time. In direct answer to your question about how easy we found it, it is not the easiest of jobs, but we are quite confident we have come up with a framework that will meet whatever policy direction the Government choose to go in.

Q247 Chair: If, at the beginning, we are unclear whether the result of the policy is to deliver a service or cash, I am unclear how it is possible to write a law which is not clear about that pretty fundamental point. Can I link that to what I think is your proposed definition of social care, “to promote or contribute to the well-being of the individual”? If the language is as wide as that, is that a definition at all or can more or less anything fall within it?
Frances Patterson: No. You have quoted what we regard as the overarching principle for the provision of adult social care. That is supported by seven factors that you can see. Effectively, they provide limits to the extent of social care. Therefore, although there is an objective to make it a wide provision, there are still limits to that. Those factors make it clear that the individual is supposed to be the best judge of their own well-being: that his or her wishes have to be followed where it is practicable to do so—clearly there will be differences if somebody does not have capacity—that their views are taken into account and that they are involved in the assessment process, if that is necessary. There are other factors as well dealing with safeguarding purposes, obviously to safeguard adults from abuse or neglect, and, if there is to be intervention, it is to be the least restrictive possible. Through that series of factors, which support the principle, we have sought to define social care for adults.

Q248 Chair: But is social care a cash sum or a service?
Frances Patterson: We have not gone into whether it should be a cash sum or not. As I have already said, we are interested in providing the legal framework which will set the basis for the delivery of services.
Tim Spencer-Lane: Can I add to that? One of the ways we have sought to deal with that is by providing a power for the Government to introduce a proper system of cash payments, if they wish to do so. That would allow the Government, for example, to set some criteria by which a service user would be entitled to receive a sum of money instead of service provision. It would be left quite open for the Government to decide to implement that sort of system, if they wished to do so.
Part of our thinking was that in Wales, for example, they have decided not to implement a system of cash payments. Therefore, our system had to cover both. We have done that, in that very specific instance, through the provision of an enabling power rather than a legal duty.

Q249 Grahame M Morris: Could you elaborate on that? I appreciate you are setting the legal framework and the underlying principles, but, now that Dilnot has been published in full and everyone has had a chance to reflect on it and look at the implications of the recommendations, is there anything you would modify in your proposals, in the light of Dilnot, that you want to share with the Committee?

Frances Patterson: The short answer to that is no, there is not. As I have said, we were seeking to produce a set of recommendations that were robust. Having reviewed them, as we have had to after the publication of the Dilnot report—although I should make it clear that, in the lead-up to that, there was liaison between the two Commissions so we knew what they were going to be recommending and vice versa—we are satisfied that our final recommendations can live independently from or, equally, can marry happily with Dilnot’s proposals. We would not change anything.

Q250 Grahame M Morris: Is there nothing within the Dilnot recommendations that would require modification to fit your recommendations on the framework?

Frances Patterson: No, there is not. There is absolutely nothing.

Q251 Grahame M Morris: They are completely complementary.

Richard Percival: We could go further and say that you could use our structure to “do” Dilnot, as it were. The tools available to the Secretary of State and Welsh Ministers in our structure enable Dilnot to be implemented.

Frances Patterson: But, equally, they do not have to be. In other words, if it was decided not to proceed with Dilnot at this time, or even only in part, our recommendations could proceed as an independent Social Care Reform Bill, dealing only with the legal aspect.

Q252 Valerie Vaz: I want to follow up on that. Obviously, you started this work in 2008.

Frances Patterson: Yes.

Q253 Valerie Vaz: Did you take into account the Health and Social Care Bill?

Frances Patterson: We were able to take the Health and Social Care Bill into account, but only at the latter stages. By the time that was coming towards publication, which was February of this year, our report was either at the printers or almost at the printers. We had reached the very final stages. Having said that, we were aware, again through some informal sharing, of likely proposals within the Health and Social Care Bill. By way of example, in relation to section 117 of the Mental Health Act, in the report we make it clear that we take into account recommendations in the Bill which seek to clarify the responsibility of the health authority. In parallel to that, we have clarified the position with regard to the social services authority. We have been able to use the proposals in the Health and Social Care Bill but, obviously, we were not able to go out to consultation on that part because of the respective time scales.

Q254 Valerie Vaz: Part of it is the Health and Wellbeing Boards. Have you considered those at all in terms of the integration?

Frances Patterson: We have certainly looked at health and wellbeing. As I have already said, the overarching principle of the statute we are recommending is that any decision made should promote or contribute to wellbeing. But I think it is right to say that we have not expressly considered the Boards, have we?

Tim Spencer-Lane: We did not, although we were aware there might have been developments there and we have left it open-ended in our duty to co-operate. The general duty to co-operate, as opposed to the specific duty to co-operate, would apply specifically to a Health and Wellbeing Board. We did not consider that in relation to the discrete duty to co-operate because we felt there may be additional burdens on that sort of board that would not be appropriate. None the less, we did try to cater for them generally.

Q255 Valerie Vaz: In reviewing that, did you have any evidence that co-operation was not taking place? You are enhancing the duty to co-operate, are you not?

Frances Patterson: We are in certain circumstances, yes.

Q256 Valerie Vaz: Did you find evidence that local authorities were not doing that?

Frances Patterson: I am not aware of any empirical evidence.

Tim Spencer-Lane: It is fair to say that there was a common concern from both social workers and their managers that co-operation was not happening on the ground. They were looking to us to provide some sort of solution to that. We can only do a limited amount in terms of ensuring greater co-operation, and build a legal framework which will allow co-operation to happen. But there are a number of factors which will impact on co-operation. It will also be about individual relationships between practitioners and about resources at a local level. All we have done is to strengthen the duties to co-operate and made them clearer about when they apply. At the moment, there is only a specific duty to co-operate in relation to a community care assessment. We have broadened that to include other situations, like a carer’s assessment and safeguarding inquiries. We think it is very important that there should be greater co-operation in those sorts of areas and not only a community care assessment.

Q257 Valerie Vaz: In your informal discussions, and having sight of various things, did you have a look at the Department of Health risk assessment that they
were looking at in relation to the Health and Social Care Bill?

Richard Percival: No, we did not.

Frances Patterson: No.

Tim Spencer-Lane: No, we did not.

Q258 Barbara Keeley: Obviously, it has taken three years to get to here and you have stated there is an urgent need for consolidation and simplification of the law, which most people would agree with. What do you see, moving from here, as the urgency or the time frame that you would recommend? Of course, clearly, as to this whole debate there is a worry about things being kicked into the long grass and not moved on.

Frances Patterson: Yes. That is certainly a concern. In terms of time scale, if I may deal with that first, the ideal would be, obviously, for there to be a slot in the next parliamentary Session. That is what we would want to see.

In terms of urgency, the reasons for that we set out in the report. As you say, they are well known and they do seem to be acknowledged. I would add to those by saying this. In terms of the current climate of economic austerity and the problems that that is throwing up, there is increased litigation, in the administrative court in particular, as a result of cuts in care packages. Whatever we can do to simplify that, in terms of the legal framework—which will have the consequential effect, hopefully, of reducing litigation—is important. So I think the urgency which is there has increased.

Q259 Chair: I understand you considered recommending a principle to reduce or remove future need and decided against including that principle.

Frances Patterson: Yes.

Q260 Chair: I am interested to understand why you decided against it. I would have thought that was, in truth, as good a definition as any of what we are seeking to argue in the context of the case for early intervention, greater integration and so forth.

Frances Patterson: Let me deal with that in this way. When we went to consultation, we set out a series of principles for discussion and to elicit views upon them with a view to considering whether they could be distilled with sufficient precision to be principles on the face of the statute. When, after consultation, we considered the responses in relation to the reduction of need, early intervention and prevention, we thought that was of sufficient importance for it to come through as a separate general statutory duty. Therefore, that is what we have recommended is imposed on local authorities. There is a duty to provide advice, information and assistance with a view to market shaping. I certainly do not want any Members of the Committee to think we have weakened in our view that that is not important—far from it—but, in terms of the eventual legal solution, we thought that was the strongest and most effective way of delivering that particular concern.

Q261 Chair: Have I understood this right? It becomes a duty on the local authority, in the whole range of its activities, rather than a duty on the social service provider. Is that the distinction you are drawing, or is it a different distinction?

Frances Patterson: The first point is that it is a duty on the local authority as opposed to on the provider. It may be one and the same person, of course, but it is on the local authority. That is the distinction we have drawn. The importance to be attached to it is recognised through the duty being placed on the local authority across the piece.

Q262 Chair: How is that different from the statutory power around social care commissioning? I accept the correction, but how does that general duty, to intervene to prevent, relate to the statutory framework within which a local authority is expected to commission social care in the context that you describe?

Q263 Frances Patterson: The general duty is there so that it will, we hope, deliver the objective of prevention and early intervention. It may be that, as part of its general duties, the social services authority does commission various services—they are not mutually exclusive—but one that is the general duty is clearly capable of an independent line. Therefore, it is more the first step—the initiation, if you like. For example, it may be that a service user has only the need for a grab rail. That may not result in any commissioning of services, but it can be dealt with as a result of the provision of advice and assistance about how they go about it.

Chair: I see. Thank you.

Q264 Andrew George: In relation to duties of local authorities, I want to be clear where the Law Commission stood in relation to consistency of both service and assessment and, if you do not mind—and I know this jumps around slightly—also the rights of the service user and their carers to an entitlement of portability as they may move between authorities. What is the most important, in the view of the Law Commission? Is it consistency across local authorities or is it the right of portability in order that service users can expect consistency of service as they move?

Frances Patterson: We have not recommended—because it would not be for us to do so—a nationally-portable assessment. That would be outside our remit. What we have done, we hope, is to make recommendations that will ease the position of somebody, say, who wants to move from Newcastle to Newark. Once they have decided they want to move, they can request an assessment from the receiving authority, as in Newark in that particular example, and they can receive that assessment so they will know the position when they move. As part of helping portability, there will be an enhanced duty of co-operation between Newcastle city council and that of the example, Newark and Sherwood district council. Therefore, you have co-operation between the local authorities and also information so far as the service user is concerned. If the receiving authority does not provide the same care package, they have to set out their reasons why that is the case. It may be perfectly satisfactory because there may be different needs as a result of moving that distance. If it is
radically different, obviously, by setting out their reasons, there is a transparent process and the service user can take whatever action is required, including legal, I dare say, if they think it appropriate to do so.

Q265 Andrew George: In that kind of case, where a service user and their carers are content with the assessment of the authority they are currently living in and are uncertain or concerned that the assessment may be less satisfactory in the receiving authority, then at least they have a benchmark against which they can contest the decision of the receiving authority, if indeed their expectations are unfulfilled.

Frances Patterson: Yes, that is right. Also, if they move, for whatever reason, to the receiving authority before an assessment is done, until that assessment is carried out, they would be entitled to have the same care package that they had in their original authority.

Q266 Andrew George: The Law Commission has no view about consistency across the country as a whole with regard to standards of service and standards of assessment. Have I understood you right?

Frances Patterson: Yes, although there are two parts. I said it was beyond our remit to recommend a nationally portable assessment because that is something of a policy decision for Government. We have made a recommendation that the Government provide a framework for eligibility. They are under a duty to do that on our recommendations. In the code of practice—we have recommended a hierarchical process and that is the third level—we have recommended that that includes advice as to eligibility criteria. Therefore, that should be followed by the local authorities, unless there is a very good reason not to do so, and would include the minimum entitlement. That is how we would envisage it working. It is a bit of a two-pronged approach.

Tim Spencer-Lane: Can I add to that? You also raised an important point about consistency of assessment, and some of our proposals would ensure greater consistency in terms of the process under which an assessment takes place. For the first time, there would be principles that practitioners would have to follow when they carried out an assessment. They would be things like taking into account the needs of the carer, for example, and taking into account any support being provided elsewhere. There would also be a duty on the social worker, on the face of the statute, to always consult the service user and the carer wherever appropriate and there would be a new right to a care plan, which seems to vary, at the moment, between local authorities. So, as to the actual standard of the assessment, there will be greater consistency, we believe, in terms of the process rather than the outcome.

Q267 Chris Skidmore: That is essentially arguing for the status quo in that there will be a reassessment taking place. You mentioned, obviously, that there would be that initial period when you would have the same level of care being provided. However, if you are someone in desperate need of social care and would like to move between local authorities, there will be a degree of uncertainty at the back of your mind that may prevent you from moving, if you wish to do so, given that the reassessment process will have to take place. Not only is there that uncertainty, which would completely negate the principle of portability anyhow, but there is the simple fact—you mentioned the added-on bonuses, which sound great—that the reassessment process itself is costing social care £2 billion a year. I wondered what you thought of, say, the Henry Spink Foundation’s proposal of a fully portable service which they suggest, in terms of making those savings, would fund its £200 million package in the first place. I know you probably do not want to comment—it is a policy arena—but you can probably see the limitations of this as either maintaining the status quo or being half way there.

Tim Spencer-Lane: You are right in the sense that we are not imposing on the new local authority a burden of always carrying on any assessment that has taken place elsewhere in the country. We are maintaining the status quo in the sense that, if a local authority is expected to pick up the bill for something, they are able to carry out a reassessment. That sounds quite reasonable to us.

Frances Patterson: But, in terms of assessments themselves, part of our proposals are that those will be proportionate to the needs. As a result of that, bringing into play the factors that Tim was talking about, there should be a much simpler process. There may be cost savings, coming back to what you were saying, as a result of that increased simplicity.

Richard Percival: Part of how we are trying to accomplish this policy neutrality, as it were, is by giving the Secretary of State and Welsh Ministers the appropriate powers. That includes an obligation, in fact, to make regulations as to how the assessment process could work. In other words, we are giving the tools to policymakers to create different forms of assessment. We have made recommendations about proportionality and so on.

Q268 Chris Skidmore: That is very important, and I can understand your position of not wanting to get involved in the political side of things and maintaining the legal neutrality. What I cannot understand is why you cannot provide a legal definition of “ordinarily resident.” That sounds a very powerful tool which would reach local authorities who, at the moment, are providing varying definitions of “ordinarily resident.” Surely, something you could help with is to provide a legal definition. It seems to me that a simple legal concept of whether someone is resident or not could be provided by lawyers.

Frances Patterson: My understanding of the background to why we have not looked at and produced a new definition of “ordinary residence” is that, in determining the scope of the project, it was ruled out by the Department of Health. That is why we have not gone there. We do deal with the concept, though, as it is now, of “ordinarily resident.”

Q269 Chris Skidmore: Do you want to follow upA in detail, that sentence? The Department Health ruled out the fact that you were not allowed to comment.

Frances Patterson: Can you answer, Tim, because I was not involved. I was not a Commissioner.
Tim Spencer-Lane: We had quite detailed negotiations about what was in and what was outside the remit of our review. It was generally agreed that any matters of new policy that would have significant burdens on local authorities would be ruled out of our review. One of those issues was the definition of “ordinary residence.”

Q270 Chris Skidmore: In terms of these discussions that you had, in terms of the scope, were they private or published?

Richard Percival: Published. We published a scoping report. Our initial phase of the project was—

Q271 Chris Skidmore: It seems odd if a review is immediately shackled, to start with, that the scope then becomes so narrow you cease to serve your purpose.

Frances Patterson: You can feel us bridling a bit at that somewhat. It comes back, in part, to what the Chairman was saying at the beginning as to the difficult relationship between law reform and policy. It was felt that “ordinarily resident” was a matter of policy definition and, because of that, it was outside the scope of our review.

Q272 Chris Skidmore: The Department told you it was a matter of policy, did they? Or did the lawyers decide that it was a matter of policy?

Richard Percival: The way the relationship between the Law Commission, generally, and Government works is that we conduct our projects completely independently of Government and Ministers. We do not go back to Ministers during the process. However, at the start, the Government are entitled to set the agenda as they wish. Part of the way in which we went about that process in this project was to spend quite a long time preparing a scoping report, which we then presented to Government. Government excised certain things from it, as it were, and we took on board some of the points that Government had made in an open sense, in consulting with them, about what the scope of the paper should say. That is the structure of it. Obviously, you can get that wrong, and you may think we have got that wrong on this particular issue, but that is the way the relationship with Government works.

Q273 Valerie Vaz: You could make recommendations and say, “We recommend there should be a proper definition of ‘ordinarily resident’”—you do not have to take something out of scope—because, clearly, that needs to be done. The uncertainty is huge. I know we have been darting all over the place, but I want to go back to the certainty because there is not certainty when you define someone in those four categories. I would have thought, as with planning policy guidance there is a set of rules—it is not actually statute. You could have come up with some sort of definition the whole country could use. Then the certainty is there. Part of what public law is about is that you should have certainty. That is what the rule of law is. You would have thought, being independent, that you could have come up with a set of guidance or rules which defines those and would probably help in the portability and the certainty.

Frances Patterson: Can I take various strands from that? First, in so far as our recommendations are concerned, we have striven to provide certainty where we can or at least clarity—clarity is possibly a better way of putting it—in terms of guidance. In so far as the code of practice is concerned, we regard that as a very important tool because that will provide statutory guidance as to how the new statute will work in terms of implementation. In that regard, that is more certain than any planning policy guidance because those are simply statements of policy from the Government. They have no statutory force at all. In the new regime that we would like to see as a result of our report, there will be a much more transparent, as well as simpler, process available in social care which will be, I would say, easier to interpret than the position with regard to town and country planning, which was my area of practice before.

Valerie Vaz: Yes, I know that. That is why I raised it.

Chair: Grahame and Barbara both want to come in on portability.

Q274 Grahame M Morris: I want to go back a little from this section, but it is all related to the nature of the assessment. I understand that we are dealing with the big picture here in terms of the framework the Law Commission is recommending, but, as a Member of the Parliament—and colleagues on the Committee will have this too—I am regularly receiving representations about inadequacies of the current system in relation to assessments. One thing in particular is that people are reluctant to apply for an assessment because they think they will be above the local authority threshold. How will your proposals—I am a layman, not a lawyer—help to resolve that issue?

Frances Patterson: We have deliberately set a very low threshold for assessment. Any person who has the appearance of need, which can be met through the provision of services, the local authority is under a duty to assess. They do not have to request it. The local authority is under that statutory duty. That should make it much easier for people to ask to be assessed if they feel they are being overlooked as a result of the local authority failing in its duty. Of course, it can be a carer on their behalf or another member of the family. It is not restricted to the person involved.

Tim Spencer-Lane: In relation to carers, we have gone further in that, at the moment, a carer can only get an assessment if they request it. We have removed that because it was very clear to us that many carers do not identify themselves as being carers. They see themselves as being partners or siblings. It would extend it in relation to carers as well.

Q275 Barbara Keeley: I have a question about carers’ needs. The carer’s rights to assessment came in, mostly, through Private Members’ legislation and then some was incorporated into Government legislation. Your proposal is that their assessment relies on the cared-for person. Admittedly, there is the difference and it would be a duty—a right. In essence, carers do not believe their rights to assessment, or to
any service, should come through the cared-for person because that is a reliance most of them do not want. My concern is that there will be a different outcome for carers through what you are proposing, and, in some cases, that would be to their detriment. MPs have tried, over the years, to move on the rights of carers through introducing that Private Members’ legislation. I am a bit worried that what you are proposing is a step backwards from that.

**Tim Spencer-Lane:** Can I reassure you that it is certainly not a step backwards? There would not be any reliance on the service user having a community care assessment at the same time. It would be the appearance of need in terms of the carer providing care for another person. It would be a very low threshold. It would not require the cared-for person to be assessed or to be receiving services. We were very aware of the Private Members’ legislation that has gone through and we were very keen to retain that position.

**Frances Patterson:** The other thing I should say is that we had considerable involvement with carers’ organisations during consultation. In terms of the approach—the low threshold Tim has spoken about—they were all supportive.

**Q276 Barbara Keeley:** What did you estimate were the resource implications of moving to that different basis of assessment? Of course, apart from assessments not happening because people are outside the system and they are not judged to have needs, there are resource implications for local authorities in undertaking a high level of assessment. It is only about 20% or 25% currently. Did you consider the resource implications of what you are proposing?

**Frances Patterson:** We have looked at the impact assessment. I am looking at Richard because he is the impact assessment guru.

**Richard Percival:** We were subject to competing factors in respect of this. One of the key points made against what was seen as a significant extension of carers’ rights was that it would indeed result in a higher impact on a local authority’s assessment bill. It is only about 20% or 25% currently. Did you consider the resource implications of what you are proposing?

**Frances Patterson:** We have looked at the impact assessment. I am looking at Richard because he is the impact assessment guru.

**Richard Percival:** We were subject to competing factors in respect of this. One of the key points made against what was seen as a significant extension of carers’ rights was that it would indeed result in a higher impact on a local authority’s assessment bill, as it were. We concluded that this would not be the case. The reason is that what we were proposing was very close to the statutory guidance on how to assess for carers, which goes further than the law, in practice, and the message we were receiving, by and large, from social workers when we consulted was that they were not using the higher thresholds we were sweeping away to refuse carers’ assessments. For instance, the “substantial and regular care” test, as it is at the moment, where there is a limiting factor on when an assessment is required, is something social workers were telling us they simply were not using. Therefore, we felt it was defensible, in the impact assessment, to say that we thought this would be a neutral change because of the way in which practice had developed around the country. There is no very concrete information on this. We came across no substantial and robust empirical studies of the way in which carers’ assessments were conducted across the country, so I am not going to claim that this is anything more than a bit of a guesstimate. But that is what we felt was defensible to put in the impact assessment.

**Q277 Chair:** There is quite a lot of, at the very least, anecdotal evidence, is there not, of carers and indeed cared-for people who are not being assessed, who, on any normal view, should be assessed? Extending assessments in the way that you are advocating must, therefore, have a resource implication, surely.

**Richard Percival:** It depends what the reason for non-assessment is. If the reason for non-assessment is the higher legal threshold, then what you say is clearly true. If, however, the reason for non-assessment is lack of knowledge—in the social worker or in the carer—difficulties with accessing social services and so on, then it is not obvious it would make a difference.

**Q278 Chair:** If there is a level of activity and we are recognising that there needs, in the assessment process, to be a higher level of activity, how is that possible without a resource implication?

**Richard Percival:** What I am suggesting is that a change in the legal test for when an assessment is due will not have a significant impact on the number of assessments done because the higher threshold is not stopping assessments being done.

**Q279 Chair:** You are saying that a change in the law would not impact on the level of assessments. It would merely recognise current reality.

**Richard Percival:** Yes, exactly. I would agree that we are going out on a bit of a limb in thinking that is the right approach. Obviously, we were concerned not to put forward a misleading suggestion in the impact assessment. At the same time, we thought horror stories that it would cost enormous amounts more to go down this route were certainly exaggerated. We did not want to have a situation in which it was being said we were opening floodgates of expenditure which we simply did not think were there.

**Q280 Chair:** It is possibly an example of the distinction between the legal framework and the policy delivery.

**Richard Percival:** Absolutely.

**Q281 David Tredinnick:** I want to ask some questions about integration, please. What grounds are there for the inclusion of a principle of integrated or seamless care and support with health and other services within the principles underpinning your proposals?

**Frances Patterson:** So that I understand the question, do you mean a supplementary factor? Is that what you are looking for?

**David Tredinnick:** Yes.

**Frances Patterson:** We have looked at the issue of integration of health and social care but not, in that part, by looking at the principles. We looked there, as I have said, about how decisions relate to the individual. You are raising a broader issue. We have looked at it through the duties of co-operation, both a general duty and an enhanced duty in certain circumstances, in particular with safeguarding—using
the safeguarding part as an example there. One of the recommendations is that there should be statutory safeguarding boards and there are to be certain definite members. We have recommended that social services, obviously, take the lead, then it is to be the police and the national health service. For the first time, that will be put on a statutory footing. That, in conjunction with the various duties of general and enhanced co-operation, will, we hope, lead to and engender a climate of greater integration. We could not go further than that because our terms of reference were for a social care statute. We are not able to step outside that particular box. What we have hoped to do is, by more clearly delineating what is social care, to make it clear for all users of the system—and whether it is the lawyer, the service user or the carer does not really matter—where the boundaries are to make the existing system much more efficient in terms of its operation.

Q282 David Tredinnick: You are focusing on improving the existing system, as I understand it. You are nodding.

Frances Patterson: In that regard, yes.

Q283 David Tredinnick: I gather you were not able to formally review the legal framework relating to the NHS. Do you think there is a need to review the law relating to both health and social care in the round, as it were? Do you think you need a fresh look at it?

Frances Patterson: We acknowledge there may be advantages in doing that in the round, but it is important to be realistic. We are trying to take a step in the right direction, and what we are doing does not ultimately preclude a review in the round, if it is thought appropriate to do so. But it is not part of our remit at the moment.

Q284 David Tredinnick: In an earlier question from Valerie Vaz, you touched on the scope of your work and the Health and Social Care Bill. You said you were not able to make a lot of use of the deliberations of the Bill because of the timing. However, you must have looked at some aspects of this Bill because it is the biggest thing going through Parliament in health care and social care. I challenge you on this. I do not see, even if the timings were a bit out, that you can say you did not look at it. I imagine you must have done in private, did you not?

Frances Patterson: We did. If you understood my previous answer to say that we did not—

David Tredinnick: Maybe I misunderstood it.

Frances Patterson:—then I apologise for that. I thought it was clear. The point about timing is a matter of fact. We were coming up to finalising our report before the Bill was published. What I did say was that we were aware of its contents in so far as it impinged on what we were dealing with because those had been shared informally. Indeed, there is express reference to the Health and Social Care Bill within the final report in certain areas. One is the area of integration—the point you have made—between health and social care and the other, in particular, is that dealing with section 117 of the Mental Health Act. We certainly were aware of it, and I would not want anyone to think we were not.

Q285 David Tredinnick: I put it to you that this Bill was widely trailed. We knew it was coming. It would have been possible to have had quite a detailed briefing behind the scenes. Surely it would have been better to delay your report until you had had a sight of it because your report, in a sense, was out of date before it even hit the ground.

Tim Spencer-Lane: What do you think is out of date?

Frances Patterson: I do not think it is out of date. I think it is very much up to the moment.

Q286 David Tredinnick: One of the key aspects of your work is the consideration of where we are going with health and social care. I am putting it to you that to have finalised your report, without giving the Bill due consideration, was possibly an error.

Frances Patterson: I do not accept that. I am afraid, and the Commission certainly does not hold that view. What we have tried to do is to take on board developments which are continually happening as reports get finalised. That is a fact of life and we have done that, in so far as we were able to, with the Health and Social Care Bill. Those parts that have impinged or were likely to impinge on our recommendations we have taken on board in the final report. Therefore, as I can only repeat, I do not accept that what we have done is out of date at all. We have sought to produce a framework that will and is able to live with the Health and Social Care Bill in so far as we knew it at the time of publication.

David Tredinnick: My colleagues want to come in, through you, Chairman.

Q287 Valerie Vaz: Do you need time to revisit that or maybe put in a supplementary report, given the mass of amendments that have been going through both the House of Commons and the Lords—and it is not over yet?

Frances Patterson: No. I am aware of that. That was my point about things constantly evolving. It is impossible to draw a firm line.

Q288 Valerie Vaz: So maybe you should flag up a supplementary report at the end, whenever that will be.

Frances Patterson: One of the things I should perhaps mention is that we were asked to accelerate our report—

Q289 Valerie Vaz: By whom?

Frances Patterson:—to report in May—

Q290 Valerie Vaz: By whom? I am sorry.

Frances Patterson: I will come back to that point—so that there was a small window before Dilnot reported in July to enable consideration of our proposals and then how the Dilnot report would marry together.

You asked “By whom?” We were asked by the Department of Health to accelerate the report, so we did that.
Q291 Barbara Keeley: Could I add this? Take the issue of integration. The health side of the structure is completely altering, all the old structures are moving, commissioning is new and even the status and role of the Health and Wellbeing Boards has changed. It seems to me that you cannot be satisfied your work is complete when the other side of the integration picture has completely changed. It has changed while it has been in this House, let alone where it might end up when it comes out of the Lords. It would seem to me that you need the opportunity to revisit and perhaps add an addendum to your report that covers the difference. How can you have predicted where that legislation was going when you produced your report?

Richard Percival: We have a degree of scepticism about whether all the changes, which are enormous, happening on the health side in fact impact on the social care side in the sense that—

Q292 Barbara Keeley: They do in terms of relationships—integration.

Richard Percival: I was going to go on to say this. Hearing the message that you are giving us, it may that be we do need to reconsider those elements. To be honest, they are relatively small elements of our report—not the central thrust—but it may be necessary for us to consider whether there are tricks we potentially missed, as it were, because of the changes that have happened. Exactly how, formally, we would do that, I am not quite sure. But it does make sense for us to revisit it, or at least to do an initial scoping exercise, to see if there is any necessity for us to revisit certain of the structures we have dealt with.

Q293 Grahame M Morris: It was a valid question my colleague asked, at the start of the session, about whether you had sight of the risk assessment the Department of Health had carried out. Perhaps you should have done, even on the basis of it being a working document, because of the implications for social care. Did you ask to see it?

Richard Percival: Personally, I do not think we were aware of it, were we?

Tim Spencer-Lane: We were not aware of it.

Q294 Chair: Can I ask a related question? You said, in answer to David Tredinnick, that the work you were doing was defining social care more closely—by implication, defining it in distinction from healthcare because it defines a different concept. Yet the policy direction, well before the Health and Social Care Bill, is in the direction of greater integration of health and social care and recognising, in terms of the service delivery for the individual, the less that distinction is recognised the more it is likely to meet their individual needs. When you were working up the definition of "social care," from a legal point of view, in distinction from health care, did you feel that was helpful or were you asking yourselves whether this is the law working in a different direction from policy and probably good practice?

Frances Patterson: We felt it was helpful to have a legal definition, in the way I described earlier on in the session, and we did not see that as incompatible with the policy direction. Indeed, our view is that, through the definitions and the purposes being clearer as a result of our report, it should make the existing direction of travel, so far as policy is concerned, easier in terms of implementation. I do not see them as being incompatible or, indeed, that there is any tension there. If anything, our contribution should ease that tension.

Q295 Chair: I do not understand. If you are seeking to deliver an integrated service in a doctor’s surgery where you want the community health team, the social care team and the primary care team all to be delivering one service, how do you help the delivery of one service by saying to them, “Here are two clear definitions of different things you are doing”?

Tim Spencer-Lane: There are two issues I would like to raise in relation to that. The first is that our framework would allow that direction of policy. If the Government decided that all social care were to be based in health care settings, our framework could apply to that.

The second issue is that we decided, quite early on in the report, that it would not be possible to define adult social care. We could only define its purpose, which is what the well-being principle aims to do. A lot of what adult social care currently provides is what other organisations do not provide—health services that are not provided by the NHS or housing services that are not provided by housing. In that sense, it was important for us to keep a very dynamic definition of the purposes of adult social care that did not exclude those sorts of matters at the margins.

Q296 Chair: That is quite helpful. What you are defining is a result rather than a service, with the implication that the obligation is to fill in the gaps other people are not providing.

Tim Spencer-Lane: Exactly, yes.

Frances Patterson: That is right.

Q297 David Tredinnick: Thank you very much. I have one other question about enforcement. How would you propose the enforcement of your proposed duty to co-operate, given that the NHS and local government have, in fact, been under a duty of collaboration since 1974?

Frances Patterson: They have. What is new is the enhanced duty of co-operation in certain circumstances, coupled with the duty on the relevant authority—whoever that is—to give reasons, even if they choose not to do so. To that extent, it is new and it will give added weight to the general duty which has been around for some time, as you say. As a result of a re-definition, we would hope that it would have added force. Should it be that the reasons given are perverse, there are certain legal consequences as a result of that.

Richard Percival: Can I add to that? We originally proposed, in our scoping paper, that complaint resolution should be part of the project. That includes, obviously, consideration of whether there should ultimately be a community care tribunal or something along those lines. You mentioned the Henry Spink Foundation earlier. That was one of the proposals they made originally to us about the scope of the proposals.
We recommended that that should be the case, and that was one area the Department of Health took out of our study. Therefore, we necessarily rely on ordinary public law forms of enforcement for the structure that we have come up with.

**Q298 Chris Skidmore:** If written reasons were given for refusal, as to those written reasons, there would be a process of appeal in place.

**Richard Percival:** Judicial review.

**Frances Patterson:** The next level is judicial review. We have not proposed any other legal process through our report, but you would have the traditional judicial review right of challenge.

**Q299 Rosie Cooper:** I would like to ask three quick questions, but make a comment first. I find it interesting, if not illuminating, that you feel the Health and Social Care Bill did not impact on your work significantly thus far, especially as the Department of Health have almost sold the impact and the integration as the raison d'être for the Health and Social Care Bill—the fact that we are going to rely on that integration. I would suggest that it feeds into the views of those of us who think we are being sold a pup currently.

I will go back to questioning. Do you consider that the failure to include a right of assessment allows local authorities off the hook, especially when a person's needs have escalated or individuals request an assessment? In going back to your answers earlier, the truth is that, however you dress it up, the reality is that, when a person goes from one local authority, the people who make that assessment do so in the light of what their authority will allow to happen. Therefore, you are getting drastically different results all over the country, and it is not right. I do not see much here that gets to the core of that.

**Frances Patterson:** I dealt with the issue of portability earlier. Obviously, if the service user knows what the assessment is going to be in the receiving authority and they do not like it, they have the choice not to move. That is one solution.

**Q300 Barbara Keeley:** Could I stop you there? How do they know that? How do they know, before making a decision to move, what the assessment will be in the receiving authority? They do not know that.

**Frances Patterson:** Under our proposals they can request an assessment from the receiving authority when they have a clear decision that they are going to move. They do not have to make the move.

**Richard Percival:** We have extended the right.

**Frances Patterson:** We have extended the right in that regard.

**Q301 Rosie Cooper:** I hear what you are saying, but, in terms of time scale and in terms of the people affected, this is another mountain to climb. Are the organisations of disabled people, which we engage with very closely, have all supported our proposals, accepting that it does not do all that they want.

**Q302 Rosie Cooper:** This is becoming like an Edam cheese. If I assess early and assess that you are not going to get what you are getting in your current authority, my suggestion to you is you do not come because you are going to get less so stay where you are because you are going to cost me too much. It does not really cure the problem, does it?

**Richard Percival:** The law can only do so much in these kinds of areas. A lot of what we can talk about here is political decision-making and a lot of it is about resources. We can do what we can to make systems work as best they possibly can.

**Q303 Rosie Cooper:** But we should not pretend. This is what is so sad about all those people out there who are relying on us to come up with a solution. If we cannot come up with a solution, we should be honest. This is like another fudge or another hurdle that carers and people have to get over. Yes, I hear what you are saying, but it does not help. If I am a high-cost patient and you are going to reassess me as getting less service than I am getting now, I am not going to be able to move.

**Richard Percival:** You are challenging us to do something that is absolutely not our job. You cannot expect us to tell the Government to produce extra money for disabled people. What we can do is make the law transparent, reduce the transaction costs and make the processes work for disabled people. That is why the organisations of disabled people, which we engage with very closely, have all supported our proposals, accepting that it does not do all that they want.

**Q304 Rosie Cooper:** Obviously, I am unhappy with where we are, but we are not going to cure that. Can we go back to whether the failure to include a right to assessment will let local authorities off the hook?

**Frances Patterson:** I do not understand the question because, as I have already said, the local authority is under a duty to assess where there is an appearance of need. That is a very low threshold. A person can
also request an assessment. They are not let off the hook, however one approaches it.

Q305 Chair: Can I come in there, Rosie? Going back to this point about the un-assessed—the people who could be helped but are not helped because they do not know—do you regard that, essentially, simply as a policy management issue rather than a legal issue?

Frances Patterson: We have dealt with that by the duty to provide advice, assistance and information, which I have already dealt with. The provision of universal services is a duty, on the local authority, to everyone. That is, we hope, to shape the market in a way which will improve the situation for people who do not know what they may be entitled to. It may be they do not want to go so far as an assessment. They may be able to meet their requirements through a phone call, picking up a leaflet or going on the internet. That may be sufficient. That is how that would be met.

Q306 Rosie Cooper: I am a carer. My father is 86 years old and was born deaf. He is profoundly deaf and has never had hearing at any point. He would not have a clue; he would not be able to access any of the things you have described. What would happen to him?

Frances Patterson: But, as the carer, you would. If you were not sure what to do, you could either go on the internet of your local authority or pick up the phone and speak to them.

Q307 Rosie Cooper: My dad is lucky he has me. What happens if he does not?

Richard Percival: The vast majority of disabled people are referred to social services, very frequently, by either carers or medical services. That is what happens in practice. We cannot put a line in a statute and have a clue; he would not be able to access any of the things you have described. What would happen to him?

Frances Patterson: But, as the carer, you would. If you were not sure what to do, you could either go on the internet of your local authority or pick up the phone and speak to them.

Q308 Rosie Cooper: We all agree there is a huge amount of unmet need, as you have described. How would you measure that unmet need? How would we ever get a feel for what it is? If a local authority knows, should they record that? How would you address that unmet need? Need is need.

Richard Percival: Yes. The law is there to provide a modality for those needs to be met and we hope we have come up with a very much improved one. But we, as a Law Commission, cannot say to the Government, “You need to double or triple the amount spent on adult social care,” whatever we as individuals might feel. That is for you, as policymakers and politicians. That is not for us, as lawyers and law reformers.

Q309 Rosie Cooper: Is it for you to construct an Edam cheese behind which the policymakers can hide?

Richard Percival: I do not quite understand the Edam cheese.

Q310 Valerie Vaz: But is it your job, is it not, to say where the law is failing?

Frances Patterson: In essence, yes. We have done that.

Richard Percival: Yes. We have absolutely said that. We have come up with proposals which we think improve the way the law does the job the law is there to do. That is not to make the decisions which you, as politicians, need to take.

Q311 Barbara Keeley: Are there not different trends, though? When you started this work we were not in the world of localism and there still were elements of ring-fencing around social care, things like respite care for carers. Carers’ breaks given to PCTs were supposed to be ring-fenced. Is not the difficulty with this whole portability issue—portable assessments—that you cannot do that with localism and no ring-fencing? You cannot do it because the decision is entirely with the local authority. At least it would be honest, as Rosie Cooper is saying, to admit that you cannot do it in a world where decisions are entirely made by local authorities and none of the funding is ring-fenced. You have no say whatsoever in what services are provided. My local authority provides to moderate levels of eligibility. Some local authorities provide only critical. Clearly, that is an enormous difference.

Frances Patterson: It is.

Q312 Barbara Keeley: This whole issue about portable assessments becomes a joke when one authority is providing to moderate levels of eligibility and another only to critical. Clearly, nobody is going to move between those authorities.

Richard Percival: The answer is that you should direct that to the Secretary of State and tell him that the eligibility framework, which we require to be made in regulations, should be national eligibility criteria. That is an argument for national eligibility criteria, which may be a perfectly good argument, and it is an argument you can pursue using our structure. That is the best we can do.

Q313 Rosie Cooper: Should minimum levels of service be specified as well then?

Frances Patterson: We have said the code of practice should include guidance as to what there should be by way of minimum levels of service. That is there. That would be in the code of practice which will be part of the statutory guidance.

Richard Percival: The law provides at the moment, essentially, a low minimum through human rights considerations. That is a matter, properly, for the law. We are saying that that should be made clear and explicit. Above that level—

Q314 Barbara Keeley: To achieve that, people have been going to litigation, as Frances Patterson said at the start. How many cases—

Richard Percival: I am not saying it is a very high level.

Barbara Keeley: It is meaningless, in a general sense, if you have to go to court to get your service rights
matched to your human rights, is it not? Surely we do not have a system where we expect people to do that.

**Rosie Cooper:** And with legal aid disappearing out of the door.

**Chair:** That is how rights, in the ultimate, are enforced, of course. I think we have run out of time, unless any Member of the Committee wants to pursue this.

**Q315 Valerie Vaz:** I have a quick question. There is a legal definition of “domicile,” is there not?

**Frances Patterson:** Yes, in different statutes there are.

**Q316 Valerie Vaz:** So it is possible to define “ordinarily resident.”

**Frances Patterson:** We certainly have not said it is impossible to come up with a legal definition. What we have said is that it is outside our terms of reference.

**Q317 Valerie Vaz:** No. What you said was the Department of Health asked you not to put that in.

**Frances Patterson:** Yes, but—

**Chair:** We do not need to go back. It is clear what was said.

**Valerie Vaz:** All I am saying is it is there, available. You can lob it back at them.

**Q318 Chris Skidmore:** The code of practice you propose, which has specified how local authorities should set out their eligibility criteria, is voluntary. It cannot be enforced in any way.

**Tim Spencer-Lane:** To be clear, the eligibility criteria would be set in regulations. One of the things we were very unhappy about was that, currently, eligibility criteria, which is, arguably, one of the most important features of adult social care, is left to guidance. We recommended that that should be elevated to regulations.

**Q319 Chris Skidmore:** Would you still retain the existing four bands?

**Frances Patterson:** That is a policy decision.

**Q320 Chris Skidmore:** I know it is, yes. The code of practice that specifies how local authorities should set the criteria, which is different from the criteria being statutory, how would that operate legally?

**Frances Patterson:** Do you mean the procedures by which local authorities set the criteria?

**Q321 Chris Skidmore:** Yes. I can understand you saying you have set the statutory minimum about the eligibility criteria and what they are, but then how would the code of practice operate, which you also suggest? Who would run the code of practice?

**Frances Patterson:** The code of practice we are recommending is a statutory one. It will go out to consultation and then it will be laid before Parliament by way of a negative resolution procedure.

**Chair:** Thank you very much indeed. That was an interesting session. Thank you.

### Examination of Witnesses

**Witnesses:** **James Lloyd,** Director, Strategic Society Centre, **Chris Horlick,** Managing Director of Care, Partnership Assurance, **Nick Starling,** Director of General Insurance and Health, Association of British Insurers, and **Andrea Rozario,** Director General, SHIP Equity Release, gave evidence.

**Q322 Chair:** Good morning. Thank you for joining us this morning. Could I begin by asking each of the new panel of witnesses to introduce themselves, please?

**James Lloyd:** My name is James Lloyd. I am the Director of a non-partisan public policy think-tank called the Strategic Society Centre.

**Chris Horlick:** My name is Chris Horlick. I am the Managing Director of the care division of Partnership Assurance. We are the largest long-term care insurer in the UK.

**Andrea Rozario:** My name is Andrea Rozario. I am the Director General for SHIP Equity Release, which is the trade association that looks after the equity release industry.

**Nick Starling:** My name is Nick Starling. I am Director of General Insurance and Health at the Association of British Insurers which represents the UK insurance industry.

**Q323 Chair:** I will, if I may, jump straight into the middle at the beginning of this session. This is obviously a session primarily about the financing of social care, in particular in the context of the Dilnot report. As I understand what Dilnot is recommending, the central proposition is that if the public sector restructures the entitlement to public sector support, in particular, by introducing a cap on individual liability, that will make it easier for the private sector—the financial services industry—to create a range of products which will enable the citizen to contribute more revenue to the provision of social care than the private sector does now. In other words, the public sector puts some money on the table and that mobilises additional private sector resource to improve the funding of social care. The fundamental question of this session is, it seems to me: is that proposition true? Could I start with Mr Lloyd?

**James Lloyd:** There are two points of clarification. It is vitally important to understand the detailed nature of the model the Dilnot Commission has proposed and the nature of the liability. It has been referred to widely as a “cap on costs.” This will cap how much people will have to pay. More specifically, it is a cap on exclusion from means-tested support. A local authority under the “capped cost” model would undertake a needs assessment, as it does now, and allocate a financial amount to somebody reflecting their need and the amount of informal care in the...
home that they receive. If they are below the means-test threshold, then, as now, they would be entitled to local authority support. If—this is the crucial innovation—they are above the threshold, the local authority will record the amount they would have received, but for the fact that they were above the threshold. This amount will be recorded on a weekly basis—"metered" in the language of the capped cost model—and when that notional amount totals £35,000, they are reassessed on a means-blind basis. More accurately, it would be described as a cap on exclusion from the means-tested support model rather than a cap on costs. That distinction has been lost on an awful lot of people in this wider policy debate. It has crucial implications, of course, for the user of financial products and the experience of people in that model or under such a system.

My second point of clarification is the Commission is very specific, in volume 2 of its final report, that it does not expect a pre-funded insurance market to grow in response to its recommendations or in response to the capped-cost model. It talks about different sorts of financial products, but in terms of pre-funded insurance, which is one of the key financial products people have often talked about in relation to long-term care and the potential for such a market, it is very specific in saying it does not expect that market to develop to any significant degree in response to the capped-cost model.

Chair: Before we go on to the other witnesses, that leaves open and does not answer—although it gives us two important bits of evidence, I accept—the central question which is whether, in your view, from other financial services products, if not prepaid insurance, a Dilnot-type structure would unlock new private funding into this sector.

James Lloyd: On unlocking new private funding into the sector, in terms of the use of financial products, the only products you are talking about are pre-funded insurance and disability-linked annuities, which are a type of annuity with a kind of pre-funded insurance embedded within it—that is, it pays out a higher income when somebody experiences a certain level of disability. I concur with the Commission that there will not be any significant growth in pre-funded insurance following the implementation of the capped-cost model. I would also argue that there would not be any growth in the use of disability-linked annuities. At the moment, such products are not available—neither are pre-funded insurances, frankly—but I would not expect disability-linked annuities to experience any significant level of growth in the context of the capped-cost model. Certainly, even if you adopt fairly optimistic assumptions about the use of pre-funded insurance and disability-linked annuities, the amounts of new money that would be brought into the system are measurable in the low hundreds of millions, in the context of a public spending gap up to 2025 across social care and disability benefits of the order of £12 billion. In the context of the cost pressures on the current system and the effects of rising demand, we are talking about tiny amounts of money that will be brought into the system.

Q324 Chair: I think that is a “no”. Can we move promptly along each member of the panel in turn, please?

Chris Horlick: I agree with James. It is probably a “no” that new money will be brought into the system. There is a lot of private money already in the system, and our contention is that that could be better spent. It could be better spent if people understood the fact that social care as we know it is not free at the point of need: it is not part of the NHS, it has never been free, and it is unlikely ever to be free. That is the start of the debate. Until there can be some clarity for the public out there—Dilnot identifies that 75% of us will, at 65-plus years old, need social care of some sort, but we have no idea that we may have to pay for it—there is no rationale for anybody to bother to save, invest or do anything to deal with the problem. An insurance product—I am bound to say, because we sell it—does exist that caps the costs for the individual, but it exists from the point of need. It is designed, in return for a single premium, to cover care costs for life. In terms of its attractiveness to the market, although it is a small market, I would contend it is a small market because nobody knows about it. When people do know about it, the uptake, in spite of the fact that it is quite a large-premium product, is very high. Of people who are presented with a quote, 30% will buy one of these things, so it would appear to be quite attractive to people. It does what it says on the tin and it starts paying from day one. There are products out there. I do not think the Dilnot model in any way would attract fresh money in. The question is, “Would the private money be spent differently?” There is some potential for that to happen.

Chair: We will come back to that.

Andrea Rozario: On whether a fixed-cost model will allow innovation in products, there is a possibility that could well help. It is certainly a starter, but there is still a need for more clarity about what the proposals would mean to individuals. As for equity release, there is clearly an argument that if people could release the equity tied up in their properties, that would bring new money into the system. The Pensions Policy Institute estimated that there is currently about £250 billion that could be released immediately. Our market at the moment is just under £1 billion a year, with about 20,000 transactions. A very small amount of that goes to pay for care. The reason for that is that people have certain views on equity release, but they are also not necessarily aware of how the products have changed, the safeguards that are available today and the fact that they could use it to help pay for domiciliary care and even, potentially, long-term care. There is a lack of information for the consumer to be able to make any choices. The products could certainly develop and evolve if we had more certainty about state benefits and the impact of equity release on state benefits, as well as about the long-term care market.

Nick Starling: Chair, it seems a little while since you asked the question so I am trying to remember exactly how it was framed. My answer is yes. What we have always said is that, leaving aside the details of what the Dilnot Commission said, if you are absolutely clear what the expectations are of the state and of the
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individual, which gives the individual the chance to plan for the future, that is exactly where financial services products—in particular, insurance—come in. If I know that I have to find X and the state has to find Y, I can start thinking about that X. The answer is therefore yes. There is lots of detail in Dilnot to go through, but it is a good basis for going forward.

Chair: I am, in a sense, relieved that the mood improved as we went along the panel. If the answer is that there is no new money out of Dilnot, it seems to me we are facing a virtually impossible bind. If I may summarise what the Committee has heard, there are two witnesses who have different sorts of financial products that could help if people knew about them, but they do not, and from the Association of British Insurers we hear that there are possibly other products that other people may develop. However, given the state of public finances, the existence of a huge gap and the knowledge that that gap is going to increase, it seems to me the challenge to the financial services industry must be to develop a structure with the knowledge that that gap is going to increase. It seems to me the challenge to the financial services industry must be to develop a structure with the Government that allows us to give—with greater confidence, frankly, than we have heard in the answers so far—the answer yes to the question I posed.

Q325 Rosie Cooper: Mr Starling, could you give us more details of how you think that will happen and what those products are?

Nick Starling: I can give a general idea because, at the moment, there is a working group with the Department of Health, which is co-chaired by us and the Department of Health—

Rosie Cooper: The Department of Health. Here we go again.

Nick Starling:—about what those sorts of products might be. First of all, you have to think about who those products are aimed at. You are talking about three generations here. You have the people who have the immediate need at this moment, who are probably 85-plus. You have people who are retired and have done all their saving; they probably have assets, in a pension and a house, and they are—I love using this word in public—decumulating. In other words, they have done all their saving and that is what they then have to do. Then you have people who are in work. If you work backwards off that, almost certainly the best advice for people in work is to have a pension. If you are saving well for your pension then, when it comes to care, needs are much more likely to be taken care of.

We have already heard about immediate needs annuities, which can work with the Dilnot system as well. There are other possibilities in critical illness and life policies which could convert when the needs arise. There are top-up policies, which top up in terms of the care provision. There are possible deferred payment policies which would pay on death; disability-linked annuities, which have been mentioned; and various forms of savings products. There are possibilities of products out there. The key is that if people know what they have to aim for at different stages of their life, there is a chance for that sort of development.

Finally, I agree with Mr Lloyd that it is unlikely you will find pre-funded products developing. It is difficult enough to get people to save sufficient for their pensions without thinking of saving for a product which they may not need for 40 or 50 years.

Q326 Rosie Cooper: Mr Starling, please do not be offended by what I am about to say. Can we find someone who thinks this will work who is not attached to or does not have connections with the Department of Health and who can give us an independent “yes”? Is it possible we could find someone?

Let me go back. You are the only member of the panel who believes Dilnot’s proposals will lead to a pre-funded health insurance market. Is that right?

Nick Starling: No. I do not think there will be pre-funded products. That is unlikely. I speak on behalf of the insurance industry, but I bring independence in the sense that, except for the immediate needs annuities which Mr Horlick provides, there are no products out there. I am not grinding a particular axe about particular forms of products. I am saying that, in a sense, we have a chance to think in quite an open way, unencumbered by a whole forest of products already out there. In that sense, the thinking we have been doing on this is independent.

Q327 Rosie Cooper: Could I ask the panel whether you believe the failure of the long-term care insurance market in the UK has been demand or supply failure?

Chris Horlick: I will have a go at that. A lot of people argue that there has been market failure in long-term care insurance. I do not agree with that because there is no market. Until people understand—sadly, I come back to the same point—that there is a chance they may well have to pay for their care themselves, they will not even consider planning for it financially. That needs to be step one. Thereafter, a lot of other things need to happen—for better information and advice, particularly delivered by local authorities who appear to be the gatekeepers for those things to happen, and so on and so forth. That needs to be the start of everything.

Q328 Barbara Keeley: I want to come back on the point you made earlier. There is a question for most members of the panel as to how on earth we are going to get this debate going. Chris Horlick said it is a small market for products because no one knows about it yet. As Dilnot has pointed out, 75% of us are going to need social care once we are over 65, yet Dilnot also pointed out that people do not think about it, do not want to think about it and, if they did think about it, they would rather spend the money on something else. We have had even more of a squeeze since the Commission put those thoughts together.

I could say to you that we as MPs are not under a huge amount of pressure to have a debate on this. There are debates about social care, but they are quite ill-attended compared with debates on things like football governance and local radio; those subjects are important to people, but social care is going to be important to everybody. How on earth are we as politicians, and you as providers, going to get a debate going on this? It seems to me that nothing is going to
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change while people do not know about it, are not thinking about it and are not planning for it.

Chris Horlick: I am not quite sure why your postbags are not full, but, if they are not, they are not. A piece of research we carried out identified that there were 29 million Google searches in a single 12-month period on “How do I pay my care fees?” As a result, we have built a website to address that. Age UK gets 2 million calls a year from people wanting help with care issues, how they fund their care and so on. I do not know why it is not coming here.

Q329 Chair: Can I be more precise? Why is it not coming to you as an industry? If people are worried to the tune of your numbers of millions about “How am I going to pay this bill?”, you could argue it is a sign that people are thinking a bit for themselves. They are not instinctively going to their MPs, they are going to Google. Why does the industry not respond to it?

Andrea Rozario: I think people generally feel that the state is going to pay for their costs.

Q330 Chair: No, they do not. They do not come and see us and say, “You are failing us.” They go to Google. Behind Google, the industry is not responding.

Chris Horlick: I think that is a fair comment. Ten or 15 years ago, long-term care insurance was going to be the next great big insurance market and five or six players came in to it on a pre-funded basis. Bit by bit, they have all left. We were the last pre-funded long-term care insurer, and I withdrew the product in the summer of last year. Why? Because nobody buys it. Why keep a product going that nobody is going to buy? It is pointless.

There are insurances that do the job. The problem is that people do not know about them. A large number of people go to websites, as we have seen, and we have built one to start to address that need. We also have a campaign underway with care homes, with domiciliary care providers and, particularly, with local authorities. It seems to me there is a real opportunity for local authorities to serve their citizens better and to save themselves some money by referring self-funders who present to someone who might be able to help them, rather than sending them away with an almost useless leaflet. The clue is in the question. If you are a self-funder, you might need help with your funding. Some independent financial advice at that point might be useful. We are currently working with about 20 local authorities—who in general, I have to say, are pretty appalling at looking after self-funders—trying to improve the process they go through to deliver to them.

Q331 Chair: Can I be clear about the thought process that lies behind the question? We are where we are. The question the Committee is interested in is: what policy levers are available to ensure that this recognised demand on the part of self-funders—because they go to Google—is met more effectively than it is at the moment?

Nick Starling: I was going to start with a slightly more personal answer to that question. The short, blunt answer is that a lot of us do not realise there is an issue until our parents get to a certain age. There is more background here which is that, in general, we are an under-protected society. I promise you, Chair, I will not do any sort of vox pop, but I imagine most people in this room know to protect their house against flood or fire. Nevertheless, a lot of people do not protect themselves against critical illness, which is all around us and we should know it happens, or take out life insurance and so forth—

Q332 Rosie Cooper: Not with the record critical illness insurance has. Good Lord. I could not recommend that to anybody.

Nick Starling: I am sorry to hear you say that. It has been transformed in recent years by things the industry has done and it is literally a life saver for many people—

Rosie Cooper: Not many.

Nick Starling:—but we are an under-protected society.

Q333 Chair: Shall we stick to social care?

Nick Starling: The thing beyond that, which is to get people to focus on things which seem to be several years ahead, is even a step further. At the risk of people saying “This is not a good example,” let us take the debate on pensions. In the last few years—it is not there yet—there has been much more awareness of the need for pensions. The win in this is, first of all, to arrive at a consensus, if it can move beyond a party political issue where everyone grasps the need to act, as happened with pensions. The analogy between the Turner Commission on pensions and the Dilnot Commission on long-term care is a good one. That is the way you start to build awareness and consensus and a realisation among people about how they need to meet their own needs. I cannot promise an answer at the click of a finger, but that is a way forward that I can see being mapped out.

Q334 Chris Skidmore: What about the idea of compulsory insurance?

Nick Starling: Compulsory insurance carries all sorts of difficulties with it, not least that you have to underwrite absolutely everybody. What do you do to people who refuse to buy the insurance and so forth? There are ways in which you can encourage and make it advantageous to people to do so—we call it soft compulsion—but compulsory systems run into a whole series of issues of enforcement and participation.

Q335 Chris Skidmore: Another side I see to Dilnot and from when constituents come to me is that people with houses or within that bracket say, “I will spend it all,” because once they are underneath the £23,000 total resources limit, they get it for free.

Chris Horlick: You then start to lose your choice about where you might end up, if you are in a residential setting, for example.

Q336 Chris Skidmore: It is a huge issue nationally. I think in Merseyside 80% of people are under that £23,000 limit and only 20% in Surrey are, so there
are these divides between local authorities. I do not know what you do about it.

**Rosie Cooper:** The way it is divided is different across the piece.

**Chris Skidmore:** The alternative at the moment, or the current incentive, is to spend it all and get free social care.

**Chris Horlick:** There is a range of perverse incentives in the social care structure.

**James Lloyd:** In response to that point, for as long as there is a means-tested system there will be perverse incentives and some households will try to game the system. There is very little reliable data as to what extent that occurs. It is very much a grey area in the current system that we do not know enough about.

Returning to the question about pre-funded insurance and demand and supply theories, it would be useful to put this in the context that no country in the world has a properly functioning pre-funded long-term care insurance market. In France, which is held up as the international leader, the take-up rate is 15%, but the products have very low premiums and so provide a very low level of cover; they could, more accurately, be described as top-up insurance. In the US, it has, in many ways, been a complete disaster: enormous amounts of money have been spent on trying to incentivise insurance through things like tax incentives and various other structures, but it has been a complete failure. At the policy level, there is recognition that it is not working and, in recent years, they have looked at something called the CLASS Act, which the Committee might want to look at after this meeting.

**Q337 Chair:** What is that concept?

**James Lloyd:** The CLASS Act—let me get this correct—refers to the Community Living Assistance Services and Supports scheme or Act, which was a policy idea for employers to enrol people automatically into some sort of low-level, long-term care insurance, but I do not claim to be an expert on it. I understand that the direction of policy has now moved away from that in the US. Nevertheless, it is very interesting that in the US they have explored this in great detail.

The key point is that the UK is not unique in experiencing major barriers to the growth of a pre-funded insurance market. It is not some sort of UK issue. The UK is not the exception. The UK is absolutely abiding by the experience overseas. There is a huge range of demand and supply-side barriers, particularly on the demand side, and we in the UK are confronted by our own unique barriers. I should say that in England we confront our own unique barriers, such as the operation of free personal care in Scotland. This rather confuse the people who, for example, live in Cumbria: the idea that they should have to take responsibility for their care costs when they could move 20 miles up the road and get it all for free.

**Chris Horlick:** Except they do not.

**James Lloyd:** That is a separate point. There is notionally the operation of free personal care in Scotland. I find it quite astounding that, in the year 2011, we are still discussing pre-funded insurance in the context of long-term care. I can only assume it is because of naivety or ideology people still think that, somehow, there is going to be this growth in the pre-funded insurance market. Even a company like Partnership, which has experience of providing those products, is absolutely clear that it does not happen. I also want to reiterate, to give some fairness and credence to the Dilnot Commission, my original point. The objectives of the capped-cost model set out in the Dilnot Commission are to give people peace of mind. It is an argument that the state should cover the catastrophic costs of care: that that is the correct role of the state. It is about the state playing the role that only it can provide because insurers cannot provide cover against catastrophic costs. It is also about, hopefully, the state providing some peace of mind to individuals. Those are the objectives of the capped-cost model. The objectives are not to see the growth of a large pre-funded insurance market.

**Q338 Chair:** Can you not argue that covering catastrophic loss is exactly what insurers do in every other marketplace?

**James Lloyd:** They do it in every other market, but for a whole range of reasons, which are well understood, certainly in the insurance industry, it is extremely difficult for insurers to offer a pre-funded insurance market with unlimited liability.

**Q339 Grahame M Morris:** This is a very interesting point. Mr Horlick said that social care is not part of the NHS, it is not free, it never has been free at the point of need and he cannot see it ever happening. You developed that when you made the reference to Scotland. For the life of me, I cannot understand the difference between a shared risk-pool in general NI contributions into health and funding, through a general risk-pool, a national social care service. If the argument is about pre-funded health insurance schemes, what better way to do it than in a compulsory way through the state? You can convince me that I am wrong.

**James Lloyd:** I certainly would not attempt to convince you that you are wrong. The key issues with free personal care, as a model of funding social care in England, have been affordability in the face of the demographics and the rise in demand as well as an awareness that, if this was to be funded out of general taxation and switched on like a light, it would be a massive new entitlement to the baby boomer cohort, particularly. The burden of paying for that would fall on the younger cohort, so proposals, certainly up until the election, started to explore how you could implement some sort of free personal care, or something close to free personal care, where the cost of paying for that as an entitlement would fall more on the people who would benefit immediately than the young cohort. I believe that is why the previous Government started to explore some sort of inheritance tax model.

**Q340 Grahame M Morris:** Mr Starling broke down the client group—if that is the right term—into three categories. I am intrigued why so few of the 29 million people searching on Google opt for the prepaied insurance model. Is that because most of them...
As previous speakers have said, nobody favours option? Their parents do—rather than younger in-work people, identified that have immediate care needs now—or fall in the second two categories that Mr Starling had identified. That is the immediate needs, yes.

It is important to understand that the immediate problems, things that have happened to them or are going to happen in the immediate future, to me to be about 50% of the problem. The other 50% is the development of new products post-Dilnot and the question is how we fund that. That seems to us the important thing.

It is difficult to get access to advice on equity release because you cannot get it on the high street. We need to be able to create a conducive environment for providers to want to operate in this market, so that there is an increase in products available for the consumer. That will drive competition and reduce the costs, and so on, and will also bring more innovation to the market, but the issues that hold the market back costs, and so on, and will also bring more innovation to the market, but the issues that hold the market back are constant struggle for the industry. If people were more aware of how equity release could have a positive impact on their lives, they would be more likely to seek out advice and take the products.

There are also immediate needs annuities. Among the 120,000 self-funders in residential care in England, 45,000 have an actuarial interest in purchasing an immediate needs annuity—that is, they have sufficient wealth such that it makes sense for them to buy one and protect themselves against longevity risk—but of that 45,000, only 7,000 currently do so. Arguably, it would be in the interests of public policy to boost that take-up, but in the context of long-term care funding in the system, you are still talking about a potential market of 45,000 out of 1 million older people in England who have care needs in different contexts and environments and the question is how we fund that.

I love using it. The answer to the first question about a national social care model is essentially a political one, and is about spending as much as anything else. I want to very quickly address the point about catastrophic risk. In fact, we did not argue either way with Dilnot. We said, “You need to be clear what the state needs to provide and what the individual needs to provide.” In fact, the products out there, which Mr Horlick provides, are the ones which deal with the long-term catastrophic end. The key thing is defining what people need to do and giving them information about how they might tackle it. That seems to us the important thing.

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I have written down that word “decumulation.”

I was talking about a potential market of 45,000 out of 1 million older people in England who have care needs. It is about spending as much as anything else. I want to very quickly address the point about catastrophic risk. In fact, we did not argue either way with Dilnot. We said, “You need to be clear what the state needs to provide and what the individual needs to provide.” In fact, the products out there, which Mr Horlick provides, are the ones which deal with the long-term catastrophic end. The key thing is defining what people need to do and giving them information about how they might tackle it. That seems to us the important thing.

It is important to understand that the catastrophic tail risk that we cover is absolutely all of it, but it is from the point of need. It is not for someone who is aged 40 with no social care needs at all, and they start paying in advance for it. It is absolutely at age 80 to 85 when someone is in receipt of care and they want to offload their longevity risk.

“I could afford this if I lived for eight years or 10 years?”

I am astonished to hear that there are products out there of which there is no awareness. It is a terrible situation to be in. That seems to me to be about 50% of the problem. The other 50% is the development of new products post-Dilnot and things like that. I am making a statement more than asking a question, but you might like to comment on it.

The other point, so there is no confusion about this, is that people come to MPs’ surgeries—I am sure my colleagues will support me in this—to deal with immediate problems, things that have happened to them or are going to happen in the immediate future, disasters and catastrophes. That is when they come to us. When nobody else will help them, we are the last port of call. It is our most valuable function as individual Members of Parliament. They do not come and say, “I need insurance to sort out a problem 20 or 30 years ahead.” I should think out of 100,000 cases, at least, I have never had one that has asked for that.
Andrea Rozario: They probably would not.

Q343 Chair: What is the view of the ABI on this rather crude solution that appears to volunteer itself, partly because of the witnesses we have in front of us? Nick Starling: I was going to support what Mr Tredinnick said. We in the ABI get lots of letters from MPs, and I am struggling to think of a single one about long-term care. They are mostly about young drivers or floods. In a sense, that is an answer to the question in that there is public awareness about things which are all around them—we all know that floods happen and so forth. There is a series of issues about raising awareness. On to the general awareness that this is an issue, I talked earlier about the way the debate on pensions has moved on, and that could be a model. As Chris said, there is an absolute need for proper formal advice. That means, for a start, people need to be directed towards that proper advice and you need to think about those giving the message—who people listen to and where they get their advice from. With the best will in the world, people may not necessarily listen to an insurance company selling products, but they will listen to an organisation like Age UK. There is not a single answer to this awareness issue. It is a mixture of real professional advice and trustworthy knowledge and people who know that advice is out there so that individuals can be directed towards it. That is some of it, plus the general awareness. You cannot produce the equivalent of a flood for long-term care, or at least I do not think you can. You can do what you can to make people aware of the sorts of decisions they have to make ultimately.

Q347 Chair: The Law Commission said in the previous evidence session that it thinks there should be easier access to assessment. Should this be part of the assessment process?

Chris Horlick: We have certainly modelled the potential take-up for immediate needs annuities pre- and post-Dilnot. As James has identified, the market could be—about 4% of self-funders take the product—45% pre-Dilnot. It would be more post-Dilnot, because the average premium would reduce due to the state making a contribution. Depending on the level of the cap, which would depend on the level of the state contribution and so on, in general, premium would reduce and therefore the uptake would be greater.

Q348 Valerie Vaz: What is the likely cost of that, do you know?

Chris Horlick: The average cost this year is £100,000, but the important thing is the context of that. Everyone normally sucks their breath and says, “Wow. That is a hell of a lot of money.” It is, of course, a hell
of a lot of money. It has to be set in the context of most people’s—or the average—honor equity in the country across the board, which is £169,000. You need to set it in the context of that because most people are selling a home to fund this premium. Of course, a typical cost of a private care home in the south of England is easily £50,000, or maybe a lot more than that.

Q349 Chair: What would be the cost post-Dilnot roughly?
Chris Horlick: That depends on the level of the cap and, of course, every case is individually underwritten. It would depend entirely on the presenting conditions. It is hard to say but we know that—

Q350 Chair: Can we skip the rest of the exemptions?
Chris Horlick: It would come down. It might be 5%, it might be 10%.

Q351 Chair: That is all?
Chris Horlick: Yes. That is because in reality Dilnot, for self-funders going into a residential setting, provides very little cap. This is badly misunderstood. It provides a cap subject to the local authority rate. The rate Dilnot used in the modelling—or the PSSI for them—was £550 a week. The actual rate across the country is more like £500 a week. If you are talking about a care home that costs £1000 a week, you not only have to pay the £10,000, in weekly terms about £195 a week to cover the hotel costs, but you have to pay the £500 above the local authority threshold as well; and of course you have to pay the first £35,000, under the Dilnot cap model, of the bit in between. You are two and a half years in before you get anything from the state. That is why the reduction of premium is not huge.

Q352 Barbara Keeley: We are back again to a big part of the difficulty being that people do not know about it. Even where they have read the Dilnot Commission proposals, they do not understand how that will operate. They think perhaps they will get something out of it that they will not. Yet, in terms of answers we have had from the panel, this lack of understanding then relies on links from local authorities who are under substantial budget pressures. They are not likely to be spending more on leaflets or information to the public than they were in the past. In fact, they are being discouraged by the communities, the local governments and the Secretary of State from spending money. They have made them cut back on newsletters, so whatever they were doing before, they are likely to have less money and are being discouraged from doing it now. Then there is Age UK. The whole front end for knowledge and understanding of the situation and the future is shrinking in terms of resources to do anything about it. All of those involved in wanting this to develop in a different way are going to have to engage in changing that situation. If everything that is unsatisfactory and not understood about this has been bad, it is getting worse because you are relying on a front end that has fewer resources to deal with it in both the voluntary sector and local authorities.

Q353 Barbara Keeley: But they will.

Can we come back to some of the points about what Dilnot is recommending—the £35,000 cap, if you like? James Lloyd talked about gaming earlier and people saying that they have greater care needs than they have. There is also the issue that there is no incentive in terms of carers providing informal care themselves. Could you comment on that? The vast proportion of care is provided by family carers, unpaid carers. What Dilnot is recommending does not help them because their contribution will not be included in the £35,000. Is that a reason to say some of that should be revisited? I have two reasons. One we have just heard, that people will not be getting out of it what they think they will be getting if the care costs are more than the local authority level. Secondly, there is the unfairness to carers in that their contribution is not recognised at all. Should it be?

James Lloyd: They are two very good points. It is worth re-stating, obviously, that across the country the vast majority of social care is provided by family and kin, particularly in domiciliary care, by definition. Currently, local authority needs assessments do take account of informal care. If a local authority assessor goes in and looks at your needs, but decides that all of your needs are taken care of by your family, then, at present, you would not receive any support. Under the capped-cost model, equally, you would not be allocated any notional support. Your meter would not go up. This produces, potentially, some outcomes which, as you imply, may need revisiting.

It is conceivable that a 75 year-old man could provide round-the-clock care to his 75 year-old wife for 10 years and then die, having saved, effectively, the state and to the system with informal care and keeping care costs down is not taken account of in the way that people’s meter increases and the speed with which people reach that £35,000 cap. It is reasonable to anticipate that some households might feel that is a little unfair. It might be something the DH would want to revisit—potentially granting local authorities the power, on a case-by-case basis, to assess individual cases and perhaps give people £15,000 at their discretion if, for example, they think that, “Yes, as a family or a partner, you have provided years and years of informal care.” In terms of providing recognition of informal care within the capped-cost model there is, potentially, something there to go back to. Your second question was about gaming. It is worth stating that, within the current system, there are arguably incentives for family members to understate their ability to provide care in order to try and get more out of their local authority. To what extent that happens, we do not know. What we know is that, frequently, carers do not get carers’ assessments and that many carers provide round-the-clock care.
James Lloyd: They could potentially, yes. It is worth observing that, under the capped-cost model, it could be that the incentives to game the local authority needs assessment would be substantially increased. For example, if somebody is at home and receives informal care from their family member, the local authority might come along and say, “Despite fairly substantial levels of disability, we do not assess you as having any need because all your needs are taken care of by the family member.” Following the assessment, it might be that the family will say, “That is rather unfair.” They will go online, look at some forums and discover that, “If we say we can no longer provide informal care, we will then start getting our notional amount and our meter will start increasing.” They will then request a new assessment and, therefore, understand their ability to provide informal care.

My overall point would be that these are very detailed features of how the model might work in practice, and they deserve to be explored in detail. Unfortunately, there is no real evidence of how the current system works, let alone how it would work under the capped-cost model and how carers would respond. It points to the need to pilot the capped-cost model, maybe giving specific funding to some local authorities to implement the capped-cost model now to see what happens: to see how they manage it, how the social workers manage it and how families respond.

Nick Starling: May I make a quick observation?

Q354 David Tredinnick: My immediate reaction is, yes, what a great idea. Let us trial it and see what happens because there seems to be a lot of uncertainty here about the outcomes—a particular level of uncertainty.

Nick Starling: My observation was going to be—and I suppose it links to that—that no one is expecting overnight change on this. It is a very long process. The one observation I would make is that most people want to be cared for in their own homes. That is pretty much the case. They want to be cared for by family members. Obviously, there may be problems about people gaming the system and we need to make sure that checks are in place and one of the things that private sector products can do is help support them do that. It is not axiomatic that the only private sector product is all about shoving someone in residential care. At the risk of being misinterpreted, insurers will want to minimise their pay-outs. If they can do that by looking after someone at home—supporting them at home—that could be a desirable outcome.

Q355 Valerie Vaz: Can I take you back to the question—I do not think Andrea Rozario and Nick Starling got a chance to answer it—about the work that was done in terms of the products that are available and the likely take-up of the products for social care? Have you done any work on that?

Andrea Rozario: You mean the financial modelling. Individual members, such as Partnership, may well have done some financial modelling. As a trade body, we do not have the budget to do the financial modelling required at this moment. There is probably a slight reluctance because we would need more clarity before we were able to do that.

Q356 Valerie Vaz: But Dilnot has been around for a while. People know that Dilnot is going to happen. You did not know what the conclusions were, but you must have some idea—

Andrea Rozario: But we do not know whether Dilnot—

Q357 Valerie Vaz: Presumably, when you are talking to the Department of Health you are saying, “Yes, we can provide the products. This will be the take-up and this will be the cost attached.” Are you able to provide that information for them?

Andrea Rozario: No. While we know that Dilnot has obviously come out with his recommendations, we do not know that they are going to be accepted and taken up. There is an awful lot of investment that needs to be done and there are concerns over whether that investment is going to pay off, if you like, because there are still not enough concrete guidelines for us to be able to come up with some modelling or to be able to invest in that modelling.

Q358 Valerie Vaz: Mr Horlick has done it, has he not?

Chris Horlick: Not on behalf of equity release products. We have done it on behalf—

Q359 Valerie Vaz: No, but you have done your own.

Chris Horlick: Yes, we have. We think there is the potential for equity release to increase, and indeed the Chairman’s suggestion, that equity release could be used to fund an annuity to cap the costs of care, happens today for people receiving care in their own home.

Q360 Valerie Vaz: My point was a general one about the products available.

Nick Starling: The ABI has not done any modelling. I know that people sometimes roll their eyes when I mention a working group, but there is a fairly intense amount of work going on with the Department of Health, at the moment, and the ABI, which is trying to land on what sort of products might arise. We think that is the point where you start doing modelling. It can be an iterative process, if you like, but Dilnot sketched an absolutely huge canvas. To try and do any sort of modelling on that huge canvas is a bit of a challenge. Focusing it down on the sorts of products which might emerge and saying, “Let us do some modelling on that and let us do some research with possible customers on that to see how people react to it,” is for the future.

Q361 Chris Skidmore: I want to follow up on the equity release schemes. If Dilnot goes ahead and then suggests that the local-authority-provided deferred payment schemes become the norm, what would be the point of an equity release scheme? Would anyone take them out? Surely it would be the death knell of those?

Andrea Rozario: It would not be the death knell. As it stands at the moment, the taking out of equity
release for long-term or domiciliary care is a small part of the market. We see that market growing. There is real potential for the market to grow as people become more aware of the fact that they can use their equity and their housing wealth to help pay for their care and offer them more choices. If the deferred payment scheme came into operation and was affordable for the individual local authorities to be able to supply that across the board, which is questionable—there is far more likely to be a partnership to be able to provide a deferred payment option, but if that was to happen—it would not be the death knell for equity release.

Q362 Chris Skidmore: Given that equity release is so dependent on the housing market—and obviously, as we have seen over recent years, there is huge variation with housing costs still rising in London or decreasing in the north-east, for instance—and we know, for probably the next 10 to 20 years that the housing bubble has burst, how will equity release work in the future?

Andrea Rozario: For those in the right age group, they have already amassed their housing wealth over the last 10 or 15 years. It has already been proven, from research from the PPI, that the biggest asset they hold is their property. Even if property prices decrease, it is still going to represent a large amount of their assets.

Q363 Chris Skidmore: Is it not, therefore, true that equity release is, essentially, a concept for the baby boomers and, beyond that, we do not know what is going to happen? Equity release, being a one-off phenomenon, we do not know how that will cascade down through the wealth of the generations beyond that?

Andrea Rozario: Yes, clearly. That is my argument as to why we need different products for different generations. The younger generations, which may not have the benefit of high house price inflation in the years to come, may have to have different options and products to cater for their longer-term needs. But those in the age group now of 65 and above have the housing wealth, on the whole, and they are the ones that are going to have the need right now.

Q364 Chris Skidmore: In terms of the future generation beyond the baby boomers, do you have any assessment of what impact equity release taking place now would have on the future housing market? Have any studies been done?

Andrea Rozario: No, I am afraid not—not that I am aware of. Individual members may have done that, but I am afraid I am not aware of it.

Q365 Rosie Cooper: I am quite depressed by where we are—almost. I hear from the panel a clear lack of confidence all round that Dilnot will be implemented, whatever the cap. The surety is not there and the modelling has not been done. Again, there is a belief that parts of it—for example, equity release—will increase, but you have not done the modelling there. We have not explored the products to the nth degree. I almost go back to where we started. The costs are great. In middle England they are talking about protecting their inheritance. What we are really now talking about is liberating your cash while you breathe so that there will not be anything left for you to leave anyway.

We start with self-funders. Does Dilnot meet the best needs of self-funders? How are they going to get the financial information? If the Chairman will allow me, I would like to offer you a reason why we, as MPs, do not get a full postbag about this. It is partially because, as you say, people believe that somebody else is going to pay for it. I think, having had three members of my family die in the last year, that the system exhausts everybody involved. The local authorities and all those people stick you on a stupid merry-go-round and do not tell you clearly about continuing care and all of that. It is a complete joke. We had the lawyers in here before, but I did not say too much because I was likely to explode. It is a complete merry-go-round, so, by the time you get to the end, you are almost accepting. The family and everybody else are completely drained and you moan like heck. If you do lose your house, you may then want to go and moan at an MP, but that is the thin end of a very great wedge. People are exhausted with this.

I was hoping that I could get some feeling from the panel of real clues—not that there would be an absolute cure-all here—as to how we are going to make a breakthrough.

Andrea Rozario: The only way we are going to make a breakthrough is this. One of the things we have been lobbying for is a working group between industry and Government. We want to converse, to be able to understand the market better and to be able to provide products and advice that are right for the customers. We appreciate that, at the moment, it is an awful journey for anybody, looking for advice and information, on where to go to get help for care costs and how you can look after your own family to ensure they are getting the best possible results all round, both financially and from a care perspective. But there are all sorts of barriers to the industry as well, one of which is the lack of a conducive environment to make providers want to operate in this market, and for advisers as well.

Q366 Rosie Cooper: What is a “conducive environment”?

Andrea Rozario: In terms of the environment, we have obstacles to overcome to be able to produce products for the customers. There are all sorts of different obstacles that stop providers entering into this market. One of those obstacles is misinformation. For instance, the media will often portray equity release in a negative way. The regulator will refer to equity release with negative terminology, if you like, and this impacts on people’s—

Q367 Rosie Cooper: You would not suggest, with equity release, that it has had anything other than a negative view. I have not looked at a current model so I would not dare to have an opinion but, in the past, it has had a really poor reputation.

Andrea Rozario: Absolutely, but that is the crux of it. It is in the past. We have been operating for 20 years.
as a trade association and we came together to put in a code of conduct. That code of conduct cleaned up the market dramatically. We now have very, very few complaints. In fact, you can measure that with the Financial Ombudsman scheme. The numbers of complaints that come to equity release compared to other areas of financial services are very low. We have put in certain criteria. However, those criteria are not necessarily recognised, the safeguards have not been recognised and the innovation in the product design has not been recognised. People’s perceptions are still negative and we consistently have to fight that negativity to be able to give people confidence.

Q368 Rosie Cooper: But is it not that, in the normal market, you ought to be doing more?

Andrea Rozario: We are trying.

Q369 Chair: We are now running out of time. Mr Starling and Mr Lloyd want to come in.

Nick Starling: I want to end up more optimistically.

Q370 Chair: Could I ask you this? Andrea Rozario has said we need a working group between the industry and the Department. I thought that is what you said, at one point, existed. Could we be clear whether that work is going on between the industry and the Department?

Nick Starling: Yes, it is.

Andrea Rozario: There is a working group between the Department of Health and industry, which we are also part of, along with the ABI. What we need is one Government Department to take ownership of equity release and perhaps long-term care products because the difficulty that we have is often, when we are dealing with different Government Departments, nobody has ownership of equity release. While there is a working group ongoing at the moment, we would want to see that continue, not just be—

Q371 Rosie Cooper: If you are part of that industry working group, why can you not make it a topic?

Andrea Rozario: It is part of the topic, but this industry group has probably only been operational since the report came out. We are talking about the past few weeks.

Q372 Rosie Cooper: How many times has it met?

Nick Starling: It is meeting a lot. I have someone in my team working virtually full time on it. This comes back to what I was saying about being optimistic. In brief, we thought the Dilnot report was a fantastic piece of work. It got to the bottom of a lot of the issues and has produced a fantastic piece of analysis.

Q373 Rosie Cooper: Which nobody understands. That is the point everybody has been making. Nobody understands it.

Nick Starling: Some of it needs unpacking, but we are promised a White Paper from Government in April. It is not a seasonal promise. It is April. There is a huge amount of work going on, so there is reason to think that there is a lot of commitment out there to making something work. We do feel in quite an optimistic frame of mind. We are certainly in a much better position than we were, say, four or five years ago when this debate really started.

James Lloyd: I have an observation. I would not want the Committee to focus too much time and attention on equity release as a single product. It is basically a way of people spending down their wealth. If the capped-cost model was implemented, the state would provide some cap on how much you might need to spend your wealth down. In the absence of the capped-cost model, equity release is just a way of saying, “You will pay for your care. If you burn your way through £150,000 worth of housing equity, using equity release, you are still paying for your care and you are using your house to do so.” You, as MPs, will still get complaining letters from people who may have sold their home to pay for their care, used a local authority deferred payment scheme to pay for their care or indeed used equity release as a way of paying for care. This is not new money being brought into the system. It is different ways that people can spend down their wealth. It takes you back to the issue of risk-pooling and the need for greater risk-pooling in the funding of long-term care. If that cannot be done by private sector insurance and different forms of pre-funded insurance and disability-linked annuities, then you are looking at other forms of pre-funded risk-pooling, as my colleague here referred to, which is effectively via the state—via taxation, via state-sponsored insurance and other mechanisms.

Chair: Are there any other points? No. Thank you very much. Thank you for your evidence.
Ev 68  Health Committee: Evidence

Tuesday 6 December 2011

Members present:

Mr Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Barbara Keeley
Grahame M Morris

Dr Daniel Poulter
Chris Skidmore
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Andrew Dilnot CBE, Chair, Dame Jo Williams DBE, Commissioner, and the Rt Hon Lord Warner, Commissioner, The Commission on Funding of Care and Support, gave evidence.

Q374 Chair: Good morning. You have brought your entire collective self with you as a Commission. Thank you. You are all very welcome. We normally start by asking witnesses to introduce themselves, but I suspect that this morning, with the consent of the Committee, that is not necessary. If we may, we will move straight into the evidence session.

I want to begin by quoting to you something said to us by the Strategic Society Centre—I am reading from their evidence to us—“The Commission was tasked to produce a spending proposal: i.e., recommendations for how money is spent by the state on care and support for the population. The Commission was not asked to produce a funding proposal: i.e., recommendations for how more money could be directed into the social care system from a variety of public and private sources.” Given your report is called a report of “The Commission on Funding of Care and Support,” that evidence surprised me, and I wondered whether you agreed that was an accurate description of what, as a Commission, you thought you were doing.

Andrew Dilnot: I do not have that quote from Mr Lloyd in front of me, but it certainly is the case that we thought of ourselves as a Commission on the Funding of Care and Support. We felt, and feel very strongly still now, I believe, that the current funding arrangements—the arrangements that people are faced with when they need to pay for their care—are inadequate, confusing and wrong. The burden of our report was to identify the problems with the current funding regime and propose one which would bring together private and public spending to provide people with the opportunity to plan and prepare in this area as they do in all other areas. We certainly thought of ourselves as being about the funding structure. Of course, that is, in the end, about the spending of money—the spending of private and public money—but yes, we tackled the funding regime. Indeed, the terms of reference that we were set asked us to make recommendations on how to achieve an affordable and sustainable funding system or systems for care and support for all adults in England. That is what we thought we were doing.

Q375 Chair: I am grateful to you. I thought it was worth getting clear at the beginning what we are talking about: that there is a funding gap—first identified by Wanless well over 10 years ago—in the most recent round in the provision of social care. Your recommendations should be interpreted, should they, as recommendations about how a new public-private partnership should be constructed to address that funding gap in the delivery of social care?

Andrew Dilnot: They are partly to address the funding gap. They are also to address the gap between people’s expectations and what they can actually do. It is not simply that the current regime is inadequately funded, but that the opportunities people face to pool risks, which we face in all other areas of our lives, we do not face here. So the current system, the way in which the funding regime works, is inimical to people taking control and doing what they would like to. We are seeking to address not only the fact that the current system is underfunded, but that the structure of the current system is inefficient as well as unfair.

Q376 Chair: Would you therefore see it as an objective of your recommendations that, while the result of the recommendations may well be the spending of additional public money, it is a very explicit purpose of the recommendations that they facilitate the direction of more private money into this system as well?

Andrew Dilnot: Absolutely. The three of us felt very strongly that at the moment, as a nation, we are not spending enough on something that matters enormously to us: our care when we are vulnerable, whether as working-age adults or as older people. We want to see more money spent. Our conclusion is that to facilitate an increase in the amount of money spent, there needs to be some extra public spending, but the main burden of that extra public spending is to facilitate increased private spending so that we can have an adequate partnership between individuals and the state. The kind of partnership we see in many other areas of life, we think, is feasible and a way of delivering much higher amounts of money spend in higher quality and diversity of care provision.

Chair: That establishes the principles of what we are trying to do. Who would like go first?

Q377 Barbara Keeley: To what extent do your proposals on future funding depend on local authorities having the funding to deal with the current crisis? Thinking of the time scale in which you developed your recommendations—you talked about increasing need, which you recognised, and there being a gap at the point you looked at it—there have been cuts since then, which are now starting to bite.
ADASS say it is about £2 billion of cuts across 2010–2012. Do you see that we cannot move to the future funding you have sketched out with the amount you have allocated if we do not fix this? Do you recommend that local authorities get more funding now?

Andrew Dilnot: The very first piece of work we had to do as a Commission was to put in a submission to the Comprehensive Spending Review in autumn last year. That was the very first thing we did. We wrote to the Chief Secretary to the Treasury, and I think possibly also copied in the Secretary of State for Health, saying that it was clearly absolutely vital the means-tested system was adequately funded. That had to be the prerequisite. Looking after the people who were most needy in terms of their need for care and who also had the lowest incomes and assets had to be the number one priority, and adequate funding of that system was essential. That was one of the things we believe led to the allocation of extra funding to social care just over a year ago.

There is little doubt—in fact, there is no doubt at all—that all that extra money has not found its way through into social care, which is something we deeply regret. We all feel that a decent society has to make sure that fundamental, means-tested floor is adequately funded. We do not believe there is a choice between these two; both need to be tackled. The means-tested system must be adequately funded and we must look after that group, but simply doing that would leave us in a situation where people were still exposed to extreme risks in a way they are not in any other area of their lives, and still we would not have the possibility of getting a partnership between individual funding and state funding. We do not think these are alternatives, but we do think proper funding of the means-tested system is essential.

Q378 Barbara Keeley: This is a small point, but do you think you can build towards your recommendations—your proposals—if, for instance, there was a substantial decline in quality and more care homes started to fold? It seems to me there is an extent to which, if the current crisis in funding causes more issues, it will be difficult to move to where you want with your recommendations. I am trying to gauge the degree to which that is an issue in the interim.

Andrew Dilnot: My own sense is that the worse the current system gets, the more difficult it gets to build on something, but also the more important it is to move towards a new regime—a regime where we can see private funding as well as public funding coming in. We would all stand foursquare behind the need to have adequate funding of the means-tested regime, but if that becomes even more problematic, I do not think it is an argument for not going forward for reform. It makes the need for reform even greater.

Lord Warner: Could I add one point? It is worth looking at what the King’s Fund said in their report last year: if you do nothing—if you do not have any Dilnot Commission—the public funding of this system will go up from £6.7 billion currently to, give or take, just over £12 billion by 2026. Doing nothing will mean that the public purse will spend substantially more money.

Q379 Rosie Cooper: You make a play about how we move forward, but we also have this great volume of unmet need out there which needs to be quantified, as you said. Do you think there are any moves towards whether that can actually be done?

To build on Barbara’s question, I was reading an article where Surrey County Council—the other end of the country from where I am, but I would suggest that Lancashire would be in a similar position—said that implementing Government proposals would cost it £102 million a year. Obviously, the exact costs would depend on the funding formulas, but that council’s director of social services thought 40% of the £102 million would fall upon the county. It would therefore become virtually impossible for them to deliver, especially in light of current cuts. How do you square this what seems to be an increasingly shapeless mess? As you push on one end—a cut—and it goes forward, all I hear is people talking about how we are going to get better quality in this mess.

Andrew Dilnot: We accepted very early on that finding solutions here—as in almost any other area of public policy—is very difficult. We are talking about trade-offs. There is no silver bullet, although we do think—I will come back to this in a moment—our core proposal tackles a huge inefficiency. As far as unmet need is concerned, and I am sure you all know our report almost off by heart, there is a figure on page 14 of the main report, volume 1, which shows that even if we assume that in 2005–2006 demand was fully met by local authority expenditure on older people’s social care, a significant gap has grown up since then. Essentially, expenditure has remained flat while demand, because of demographic change, has risen. There is no doubt that there is increased unmet need. Quantifying it precisely is extraordinarily difficult. The first piece of work I ever did as an economist was trying to measure the scale of tax evasion. The informal economy is, by its very nature, things that are informal which you are not capturing in the system. I do not think we can know how big it is, but it is significant and it is growing.

Q380 Chris Skidmore: Yes, but do you accept the 4% per year figure that has been bandied around by the Department? Apart from it being unquantifiable, there seems to be some broad agreement that that is roughly where it stands.

Andrew Dilnot: In terms of a rate of growth in demand, yes. We can know the rate of growth of demand because we know, for example, that the number of people aged 85 and over will double over the next 25 years. What we cannot be so sure about is the current level of the gap between spending and resource.

How do we square this? We are absolutely convinced we need more resource. If we are going to get better quality, more diversity, more choice and better care we need more money going in. Let us call it “money” rather than “resource”. Our recommendation is that there is a way of taking that forward by bringing together the public and the private sector and by
allocating a little extra public money to take away the worst of the fear under the current regime, and by doing so we hope that will release significant spending. At the moment, one of the biggest problems in the system is that people are so terrified of ending up in the tail end of the risk distribution they will not spend any money, particularly early on in their care journey. We believe we have the structure of a system that can make a big difference, but to unlock that we need some extra public funds.

Q381 Rosie Cooper: I understand what you are saying, but we had various organisations before us a few weeks ago and we asked them whether they thought new providers of what we will call “insurance policies” would come to the table. Other than the person who was working at the Department of Health, the answer was a uniform no, although there was the possibility of equity release and that kind of thing. So those people do not appear to be racing to this market, especially in the light of the Secretary of State’s comments that perhaps this is too expensive and we cannot afford it. No doubt, we will be talking about the cap later. When you get your proposals implemented in whatever way, on the figure that falls on the county councils or the local authorities, what split do you think there should be between them and the Government? That is what my original question was, because 40:60 is—

Andrew Dilnot: The answer is that it will vary enormously across the country. Take Surrey; I spent a very interesting morning down in Surrey a couple of months ago with Sarah Mitchell, the director of adult social services there, and 400 of the people who work in that sector. In Surrey, the proportion of self-funders is enormous. Surrey is a relatively affluent part of the country. There might be other parts—the centres of some large cities such as London—where self-funders would be a much smaller proportion. The impact of proposals like this would vary radically between a rich part of the country, where a significant difference will be made, and a relatively less well off part of the country, where the difference will be much smaller. There is not a number we can apply to local authorities because it would vary enormously depending on how affluent that local authority is.

Q382 Rosie Cooper: I have a final question for you. Do you think the self-funders are the most overlooked and under-served people involved in the care system?

Andrew Dilnot: I will allow my colleagues to come in on this one because that is a difficult question. By and large, I avoid making ranking lists. My view is that everybody in the social care system is inappropriately served at the moment. That means all of us: I have said again and again that the risk or probability of needing care in your old age is greater than the risk of falling pregnant. Half of us are not going to fall pregnant and three quarters of us are going to need care in our older age. At the moment, we have a system that does not work for any of us effectively. It does not work for people as they look forward to the possibility of needing care and it does not work for people at the point where they need care. The system is bust. I would be wary of saying there was a particular bit of the system I thought more bust than any other, but let me turn to Jo or Norman to see if they have anything to add.

Dame Jo Williams: One of the issues with the current system we were very clear about—certainly when we talked to people either in receipt of care or with family carers—is that there is lack of clarity and good information. We met many people who had struggled for many years without knowing how to access the right sort of information and services. Clearly, those who have had no involvement with the local authority through social services may be even more mystified by the system than people who have already made contact.

Q383 Rosie Cooper: I am sorry, but I may not have directed the question sufficiently. There is a great anger among self-funders. They pay extra when they go into care homes to make up the fees of those paid for by the local authority, which pays reduced rates. Those self-funders are not only paying for themselves but are contributing to other people’s care. How unjust is that? Are they under-served and do they have to over-provide?

Lord Warner: It certainly was said to us, and has been said to me by many providers of residential and nursing home care, that the local authorities, as their funding has been more stretched, have done two things: they have tightened the eligibility criteria and they have reduced the unit price they pay for the state-funded residents in their homes. The consequence is that providers have been able to keep going, basically, by having differential pricing in many of their homes where they have a mix of self-funders and state-funded. Inevitably, that means a degree of cross-subsidy in reality, I suspect.

The other bit, which was put to us very strongly, was that the ability of self-funders across the country to get good information about what services were available was very mixed. That is why we made a recommendation that local authorities should have a wider set of duties in relation to making information available about the services in their particular areas. There was a sense that the people paying their own way, if I may put it like that, were not getting a good service in terms of information and ability to access services. There was a double whammy on the self-funders.

Rosie Cooper: I think most of the country thinks they are being ripped off.

Q384 Valerie Vaz: I will stick with local authorities but, first, let me say that you have done a huge amount of work and that whatever happens to the report—I hope something does happen to the report—clearly it is there for everyone to see.

Did you manage to speak to all the 152 local authorities who deliver care? Did you get some information from them on how much they spend?

Andrew Dilnot: I spoke to the Local Government Association on a number of occasions. I spoke to ADASS on a number of occasions. I spoke at NCAS. Yes, we spoke in large fora and we also spoke with representatives of individual local authorities. The Local Government Association and ADASS were
extremely helpful to us throughout. One of the striking things about this area is that data is not as readily available as one might expect it to be because it has been a local authority responsibility. We had to rely quite heavily on data from local authorities, so yes, we had extensive discussions with them.

Q385 Valerie Vaz: Is spending on services different in each local authority?
Andrew Dilnot: Yes, it is radically different. One of the striking things about spending in this area—one of the things it is important to recognise—and one of the reasons it has been so hard hit in the last year is that it seems local authorities were spending more than they were allocated on social care, so when their overall budgets were cut, the social care budget was cut particularly hard. Local authorities like spending money on people who need to be looked after. It is not the case that social care is an unpopular thing. If you are running a local authority and you have somebody in front of you who needs care and support, by and large you want to give it. One of the reasons it has been especially hard in the last year is that, given how much was being spent, when the overall local authority budgets were cut, the impact on social care was multiplied because more was being spent than had previously been allocated.

Q386 Valerie Vaz: Given this is a national issue and one for society as a whole, how would you recommend that national Government and local government deal with this together?
Andrew Dilnot: This might take us on to some new areas. Before I go on to that, can I say, in response to Rosie Cooper’s remarks about the role of the private sector and financial services, and I hope we will come back to that—
Valerie Vaz: Yes, we will.
Andrew Dilnot:—we think there is an argument for variation in exactly what care is delivered across different parts of the country. The appropriate way of looking after someone in the Lake District and someone in Lewisham will be different. Even if their needs are the same, what is appropriate in a rural area in terms of care may be different in a city. That degree of variation, we think, is sensible, but we are not at all persuaded that variation in eligibility makes sense—I might ask Jo to say more about this in a moment. That seems to us simply wrong. One of the most unanimous responses to our consultation was people saying, “We do not think this is right.” That leads you to take a different view about processes of assessment. We have a strong view that the current processes of assessment, while well intentioned, are too subjective and too complicated and they do not work. We argue strongly that local government and central Government need to come together and say there are national eligibility criteria and there are national assessment processes. The way in which care is delivered may vary, but not the question of whether you are entitled to it. Jo, is there more you want to say?
Dame Jo Williams: The only thing I want to add is that we heard from many people who were saying not only are the assessment processes very complex, with many having to repeat a story over and over again, but there should be the opportunity to take their assessment to a new area—the portability argument. People felt that, having reached a level of assessed need in one local authority, it should apply elsewhere with, as Andrew says, potentially different services because of what is available in that area. Those are the two things we felt could be addressed quite urgently: to come up with a universal assessment system, which would be much clearer and much more transparent, so that people could understand the basis for the decisions being made; and that that assessment could go with you wherever you chose to live, so that if your relative was looking to get you nearer to them, or whatever, that would be possible. I think there was great support for that.

Lord Warner: The other thing that people did say about the situation was that, in different areas, there were different abilities to access the NHS for continuing care. The assessment processes for continuing care did vary quite a lot. Certainly, when we looked at the actual process the Department of Health has for continuing care, it would be a masterpiece of understatement to say it is a little opaque. There is a set of issues about national interpretation of entitlement to NHS services for continuing care.

Q387 Dr Poulter: I want to pick up on a couple of points that have already been made. First, Andrew Dilnot made earlier what to me is a key point: that the worse the current system gets—or words to this effect—the more difficult it is to build on your recommendations for the future. Lord Warner, I would be very interested in your view on this as well. At the moment, there is very much a focus upon better integrating adult social care with NHS care, and that is something you touch upon in the report. Is that something you feel is absolutely essential if we are going to have a sustainable and better system for today but also something which, if your recommendations are implemented, would be able to be built on in an effective way?
Andrew Dilnot: We do think it is essential. One of the earliest pieces of analysis that we asked our colleagues on the secretariat to do was to draw us a chart—reproduced on page 57 of our report—which shows how much public spending in England there is on older people. It shows that total spending is about £145 billion a year: nearly £3,000 for every man, woman and child in England is spent on an older person. Of that, more than half is social security benefits, principally the state social security pension, but also housing benefit, pension credits and so on; £50 billion is the NHS; and just £8 billion is social care. It is pretty clear to us that, if you started with a bar that was £145 billion high, you would not draw the lines in that position, particularly the distinction with this very small amount of separate money spent on social care and the much larger amount spent on healthcare.
I will turn to Norman in a minute, who is much more expert on this than I am, but our strong sense was that the balance is not right and there is inefficiency and reduced welfare as a result of that split between social...
care and the NHS. Because of the way the systems work at the moment—the lack of pooled budgets and of working together—there is a barrier to getting sensible allocation of resource across the piece. We need to tackle that. We think it is essential, and certainly something to be looked at. It is a slightly different point to the point that leads us to the cap and the change to the means test, which is that the current funding system is nuts.

Q388 Valerie Vaz: Our map says it is a £100 billion for the NHS and £50 billion for social security. Is that right?

Andrew Dilnot: In total, it is £145 billion. The first £85 billion is social security. Then the next £50 billion is NHS and then the little slice at the top is social care.

Lord Warner: This issue of integration has been around for a very long time. Successive Health Ministers have made grand speeches about integration of services for at least 20 or 30 years. The real problem has been defining what you mean by it and looking at how you can deliver it. As far as our report is concerned, there is nothing in it at all which thwarts integration. In a sense, our report helps the personalisation agenda, where you can mix and match state and individual funding for putting your own package of care together as an older person. There is nothing to stop that in this report. The real problem people have been struggling with—it has come up time and time again in the Health and Social Care Bill, which is wending its way slightly slowly through the House of Lords; we have had a number of debates, and we will have another go at this tomorrow on integration—is finding some mechanisms which will deliver it for individual people. At the core is the point I made just now: the problem of the different interpretations of what the NHS is responsible for in terms of continuing care in different parts of the country. That does cause a problem. It seems to cause a problem, from the evidence given to us, in the area of dementia, where you have quite variable interpretations in different parts of the country as to whether a person does or does not fall on the health side of the line. What you have is a boundary which is often about avoiding taking responsibility for costs rather than a boundary which is more porous in terms of people integrating care.

Q389 Dr Poulter: What you are saying is that, at the moment, we have arbitrary boundaries in the system between social care and the NHS which are cost boundaries but not boundaries that benefit the patient or the person. Is that a fair assessment?

Lord Warner: Except in some places like Trafford, where people are trying very hard—an excellent report has recently come out from the Nuffield Trust on Trafford—and Torbay is always mentioned, but in population terms they are relatively small areas.

Q390 Dr Poulter: I have one other simple question which will, hopefully, be quick to answer. Lord Warner, you also made the point earlier about the King’s Fund report that looked at the increasing cost of caring for an ageing population. That is quite an important piece of work. What I am trying to draw from you as a group is this. Your costing implications about where a cap would be and what costs would fall to the taxpayer are, effectively, cost implications for today, but if we put off this decision about possibly tackling the larger issue of how we are going to fund adult social care, what we are saying is that the costs could go up dramatically—possibly by, I presume, several billion pounds—by the end of this decade. Is that what we potentially are saying?

Andrew Dilnot: I always like to talk in terms of percentages of GDP because then we do not have to worry about inflation and how big the economy is. Our core recommendation would cost 0.14% of GDP at the moment.

Q391 Chair: Can I make the point that people pay taxes in pounds rather than percentages of GDP?

Andrew Dilnot: They do, but the amount of tax they pay rises as inflation increases their income and as the economy grows. As a share of national income, the current cost would be 0.14% of national income, one seventh of 1% of national income, if the scheme had been fully implemented and was fully mature now.

Q392 Chris Skidmore: On top of GDP spend of, what is it, 1%?

Andrew Dilnot: That is, on the total social care bill, slightly over 1% of GDP at the moment. That would rise, over the next 10 to 15 years, to 0.22% of GDP, so from 0.14%, one seventh of 1% of GDP, to 0.22%, slightly over one fifth. The rise is driven by the very substantial increase in the number of older people. The number of people aged 85 and over is going to double.

The only other thing I want to say there is that, again and again as I have spoken about this, I have emphasised that we should be delighted. I hate people talking about “the burden of ageing” because I quite hope it happens to me. The alternative to the burden of ageing is the burden of being dead. I would far prefer the challenge of reallocating resources within the national economy and within my own personal economy because I am living longer than previous generations. We have got into a bit of a muddle in thinking about something we should celebrate. It is fabulous that we are living longer. It is a result of much improved healthcare and nutrition and much improved average incomes, which means we have to make new choices about how we allocate the much larger level of income and wealth that we have than our previous generations. We are on average four times as well off as generations 50 years ago. To say that we cannot afford something like this always seems wrong to me. We have to make choices, and they are difficult, but they are choices we are empowered to make.

Q393 Dr Sarah Wollaston: The trouble is that everybody thinks somebody else should pay for it. Can I return to the point that you raised at the beginning about this being a private and public partnership? How far do you think this will be undermined by the mis-selling which has been in the news this week with HSBC? How likely is it that older
people are going to want to take out these products when they look at what has happened?

Andrew Dilnot: Let me stand back a little from this. I will come directly to that point in a moment. There has been some confusion. It seems to me there was a little confusion in some of the evidence that was heard a week or two ago about precisely what we are saying about the partnership between the state and the individual. It is clear to us there needs to be greater private spending than there is at the moment. That is not the same as saying there needs to be greater private saving. One of the effects of the current system is that, because there is no risk pooling—you will all have heard this from your constituents—you find people of very moderate wealth frightened they may end up needing residential care for some considerable time which they will have to pay for themselves, until they are to down to their last £23,250. They are terrified of spending and they are hoarding assets against the not very likely probability they end up needing residential care for a long time. The biggest effect of our proposals, by taking away the worst case—by saying to everybody, “The worst case you will face is that you have to spend £35,000 on your care, not £150,000 or £250,000”—will be the release of spending.

The way that risk pooling works is this. Imagine a world where somebody thought the worst case was they might have 20 years in a residential care home. Under the current regime that would mean they would need to have to have £600,000 of assets which they must not spend on anything else just in case they end up here. Under our new regime, they know the worst case is £35,000 of the assets they have accumulated. Many people have accumulated assets—not massive, but most of the population now has housing and a little bit of saving—and they will be able to spend that resource. The response to our report’s recommendations for many people will be, “If that is the worst case, I do not mind that coming out of my house when I die. I am now willing to think about putting in a handrail, a stair lift or a downstairs loo because I am no longer so terrified.” A lot of what will happen, I think, is the release of spending. That is what happens when you pool risks. Will there be new products? Yes, I think there will be new sorts of products. There will be a variety of products. Most of them will be based on either houses or pensions. The way the tax system works, those two assets are so much more tax privileged than anything else it is very difficult to save in anything other than houses or pensions. With houses, we will see the effect of new and better equity release schemes coming through. The reason that will work better is, at the moment, if you go into residential care, you do not know how much you might need to take out of the value of your house. It is open ended. I think we will see simpler and better schemes.

As to pension-related things, our view is that care in older age should be thought of as part of the ageing process. It should be tackled in the same way that we tackle all the other financial consequences of growing older. At the moment we cannot do that because there is nothing to grasp on to. Our own conversations with the financial services sector have been very encouraging. We spoke throughout the term of our Commission to many representatives of the sector. At the launch of our report, the Chairman of the Association of British Insurers, the industry body, who is also the chief executive of Legal & General, said that, as an industry, they are ready to provide innovative solutions for funding long-term care. He said, “What we need going forward is a clear, stable framework. This report offers hope of just such a framework, agreed between government, the insurance industry and care providers.” I think the industry will come up with products that will help people. We can talk about those in more detail later perhaps.

As to HSBC, of course, it was a terrible, terrible thing. Over the last 30 years that I have been active in this area, we have seen repeated problems across the financial services sector, and each of them does damage to confidence. They do particular damage to confidence in markets that are very small, which this one has been because it has not been a well-functioning market. It is important to remember that there are other aspects of the financial services industry that do a pretty good job for most of us. I suspect most of the people in this room own houses which they have been able to buy through the services of the financial services sector. Most of the people in this room have pensions with which they are probably not entirely satisfied but at least are better than nothing. We need to recognise that financial services are complicated, that they are not well understood and that it will be difficult to get a market to grow effectively, but we are confident that it will grow. We have spoken, as I say, to representatives of the large players who are not in this market at the moment because there is no good product for them to offer. They are confident that, with the kind of system we describe, there would be a space. They will have to work very hard to overcome the consequences of things like the HSBC scandal, but they will be able to because we all need that help.

Q394 Dr Sarah Wollaston: Thank you for that. I want to follow that up with a quick question about how realistic the cap will be. If you are a resident in a relatively expensive nursing home, say, and you have used up your cap, is it realistic that the extra costs would then be topped up by the taxpayer? If not, surely those people are still going to end up paying for it themselves or being cross-subsidised by other residents, as was touched on earlier?

Andrew Dilnot: It is absolutely clear to us that the amount local authorities should pay should continue to be constrained. Let us imagine my choice, in 40 years’ time, is to go and stay in a very expensive hotel and be looked after there. It should not be the taxpayers’ responsibility to fund that, even once I am beyond my cap. The taxpayers’ responsibility should be to provide funding at the level the local authority would deem appropriate. That would mean people have the capacity to top up in a way that would be much more straightforward than is the case at the moment. Certainly, the taxpayer should only provide support at the level that, as a population, we think is the level that should be delivered. If somebody...
chooses to stay somewhere more expensive than that, with higher general living and accommodation costs, they should be free to do so. They should still get the support they would get if they were staying in the standard sort of place, but if they want to stay somewhere more expensive they should be responsible for that payment themselves. That is an example of the kind of financial product which I think will develop quite quickly and is relatively straightforward. It will not be related to care costs. It will simply be related to accommodation costs. One of the markets I suspect will grow up first will be top-up provision for people who want to choose to stay in more expensive accommodation.

Q395 Andrew George: Can I come back to the point you make on page 57 of the report about the totality of funding? You make some very good points there about looking at the amount of money going into the NHS; how much money is spent on older people in the NHS through DWP as well as social care, and the perishingly small amount, relatively, going into social care. Your commentary on it implies it is very imbalanced against social care, but do you not address the issue of how you go through a transition. I know you raised this with Government at an earlier stage, but is not the reality that any transitional arrangement would need to be front-loaded? You would not withdraw hospital services from older people unless you had improved the care services in advance of that. You would have to have front-loaded the care services in advance of that, and that is going to cost money. Is that not true?

Andrew Dilnot: Norman, would you like to answer this?

Lord Warner: Up to a point, is the answer. You have to start from the position about what happens if you do nothing. On the evidence available, the effect has been that as local authorities have tightened the criteria for eligibility, in some parts of the country more elderly people have ended up in NHS care faster. That is, in fact, what has happened. Logically, looking at the chart on page 57, the boundary will shift. The 6% may stay static. The 35% NHS may increase over time, if you do nothing.

The situation is that the organisation which takes up the “slack” in the system, if I may put it that way, is the NHS. That is inevitable. Then you get into a set of judgments—which we certainly did not look at but they probably do need to be looked at—as to the spare capacity in the adult social care field and whether there is spare capacity also in the medical wards of acute hospitals. They are the two systems in play. It was not our job to look at the delivery systems. You are right in a sense, but I am not sure that anyone knows what the spare capacity is in those two systems, and whether, if you started progressing more money to the adult social care system quite quickly, there is enough spare capacity to take a lot of people out of NHS care into publicly funded care in the adult social care sector, the nursing homes and the residential care homes. That then sets up another set of issues which the NHS has found difficult to deal with. What do you do with the spare beds you have actually created in the NHS? The costs you have to take out of the system then become nothing to do with the adult social care sector. They are all to do with how you release the money from the NHS sector.

My personal view would be that there is a serious piece of work to be done by the Department of Health on that issue and mechanisms for releasing costs from the NHS and transferring them over the boundary.

Q396 Andrew George: Let us face reality. That is rather fanciful and theoretical, is it not? The LGA are currently telling us that the net effect of recent spending has resulted in about £1 billion being taken out of frontline social care. That is quite the opposite of front-loading social care so that the pressure is taken off the NHS. That bar chart, or whatever you call it—you are a statistician, so you will be able to explain what it is to me—or piece of cake that is sliced up in that way ends with up with a larger slice going to social care, with less needed for and going into the NHS. Although yes, there are of course pressures on the NHS to discourage unnecessary admissions and to discharge much earlier—we know that is going on—those are pressures going into the system to try and cut that budget. The reality is that nothing is going to precipitate a change in the relative spending in those two areas. Is that not right?

Lord Warner: No. My analysis was not fanciful. My understanding comes—and your Chairman has made some excellent speeches on this—from what is called the Nicholson challenge: £20 billion to be taken out of the NHS over four years. The question is what do you do? You could be very sceptical about whether the NHS will deliver it, and I would join you in that scepticism, but, theoretically at least, it is Government policy to take that £20 billion out over four years, or perhaps a bit longer. There is then an issue about whether you use any of that money to enhance capacity in the adult social care sector. I fully accept that the reconfigurations involved in the NHS are politically difficult, managerially difficult and all the rest of it, but I do not think it is fanciful, given the Government has committed itself to making that £20 billion saving.

Q397 Andrew George: What has the Government said in response to the point you are making about the relative balance of funding?

Andrew Dilnot: In their Comprehensive Spending Review, they allocated some funds from the health service to social care. I am an economist so I believe in “reveal the preference”—look at what they do, rather than what they say. What they did—surprisingly—was take £1 billion out of the NHS budget and swing it across. It would be surprising if reasonable people did not think this was one of the ways in which you might increase the overall efficiency of the system. We all know there is enormous budgetary pressure in all these areas and we can also all see that one of the areas where there might be greater scope for efficiency gains would be in sliding activity across the boundary, but of course it is not straightforward.

Q398 Andrew George: You also said that the system is bust—the system is bust and there is an urgent issue
which needs to be addressed. You did not comment on the extent of the sustainability of the current system, which is built on the backs of the lowest-paid people in this country being expected to do jobs which no one in this room would be prepared to do, particularly at that wage, all hours of the day and night. Do you think the current system is sustainable as far as that is concerned, or do you think we can take those workers for granted?

Andrew Dilnot: We think the current system is unsustainable in almost every way because it is not doing a good job. It should be the system that looks after us all when we are at our most vulnerable. There is some marvellous care being delivered in this country by informal carers and by formal carers. When you go and see the care being delivered, often you come away very moved and with enormous respect for the people who are delivering it. However, the system does not work. There is not enough funding going into it overall and people are faced with a degree of fear and uncertainty that they are not faced with in any other area of their lives. As a result, we are not looking after the market as a whole, we are not getting the kind of diversity and choice we should expect, and we are not always giving the right level of sustained support to those delivering the care. It is bust in every dimension.

I would go back again to the Government’s Coalition Agreement—I am sure the Government remember every part of it with delight—where they said: “We understand the urgency of reforming the system of social care to provide much more control to individuals and their carers, and to ease the cost burden that they and their families face.” We simply say, “Hear, hear.”

Q399 Grahame M Morris: There are a couple of areas, which you have already touched on, that I would like to cover in a little more detail. One is the whole basis of the Commission’s report. As Lord Warner said, the Commission were charged with coming up with a set of proposals that were fair and reasonable. My question is: is it fair to characterise these proposals as regressive, given that the bulk of the support still goes to the poorest 60% of the population. So no, I quite disagree with that characterisation, which I am sure you do not share.

Andrew Dilnot: The short answer is no. It is important that whenever we talk about “regressivity” or “progressivity”, we talk about the system as whole, both the revenue-raising and the spending side of it. At a very simple level, if you were to ask, “Where does the money go?”, 80% of the extra funds under our proposals go to people with housing wealth of less than £200,000. That does not sound like very much to me, as only about 10% of people have housing wealth of less than £20,000. Again, looking at people at the lower end of the income spectrum—people who do not have property to sell—how would they mitigate these care costs? It would swallow up all of their income, would it not, because they could not share.

Q400 Grahame M Morris: You gave the earlier example of an individual in Surrey, I think it was. It was a very useful explanation about risk pooling and the fact that having a system like this in place would release spend. You suggested that individuals might be holding back £600,000 worth of assets. There must be a huge geographical spread. In my area, that would be a huge sum of money and there would be a relatively small percentage of people in that category. On the same theme, I come to the recommendations regarding contributions towards living costs of between £7,000 and £10,000. Again, looking at people at the lower end of the income spectrum—people who do not have property to sell—how would they mitigate these care costs? It would swallow up all of their income, would it not, because they could not mitigate by selling property to generate income?

Andrew Dilnot: The reason for the points we make on living costs is this: one of the general principles we had throughout our work was that it was very important the funding regime did not discriminate between different types of care. At the moment we have a regime where, if you are in residential care, your house counts. There is a financial incentive for local authorities to get you into residential care so they can take that asset into account, and there is a financial incentive for individuals to stay in domiciliary care. We wanted to remove that. If you are in your own home, then of course you pay for your heating, food and all your accommodation costs. It seemed to us right that the same should be true in residential care.

Q401 Grahame M Morris: But what if you live in accommodation rented from the local authority or a private landlord and you cannot mitigate those living costs by selling your house? All the income would be swallowed up, would it not, in your notional £7,000 to £10,000?

Andrew Dilnot: It is certainly the case that, just as your income will be spent on your accommodation costs if you are living at home, it will be swallowed up if you are in residential care, but if you are somebody who is dependent entirely on state social security benefits, you will be no worse off than you are under the current regime.
Q402 Chair: Presumably the move from £23,250 to £100,000 would help protect that family.
Andrew Dilnot: Yes.

Q403 Rosie Cooper: This a left-field question. When you did this, did you do it as an academic exercise; or did you go out across the country into residential care homes, and if so, how did you choose them and what did you see?
Andrew Dilnot: Did we do it as an academic exercise? We certainly brought all our skills to bear, including our intellectual ones, and thought very hard about it. We began with a process of thinking, but we did that based on a great deal of engagement with individuals, organisations and care homes. Jo might want to say more about this. We tried to make sure it was built on people’s lived experience through our own engagement with them and also through a whole variety of exercises to engage them.

Q404 Rosie Cooper: Did you go into the homes?
Dame Jo Williams: Yes, indeed.
Andrew Dilnot: Yes.

Q405 Rosie Cooper: Was that across the country?
Andrew Dilnot: Yes. I went to all parts of the country. I visited all of the devolved Administrations.

Q406 Rosie Cooper: Did you go to Liverpool?
Andrew Dilnot: No, I did not go to Liverpool. I did go to Scotland, Northern Ireland and Wales and I went to Bristol and Reading. Jo can also list some of hers.

Q407 Rosie Cooper: There is no big metropolitan council in that list of places, is there?
Andrew Dilnot: Newcastle.
Dame Jo Williams: Aside from doing visits, we met with a wide range of carers as well, so we heard stories from people directly. The other area that we looked at was some of the new developments in terms of people making choices to move into what you might call extra care housing. Again, people were telling us their stories about why they had done that. Interestingly, one of the things that kept coming up was that, for many older people, the difficulty of giving up their own home is that they do not feel safe. It was increasingly an issue for them that, living in their local communities, they were not feeling they got the right kind of protection, in a way. Some of those people had chosen to go into, as I say, extra care housing and felt very positive about it because there were all sorts of activities going on. They had worked with the organisations providing that service, looking at the totality of their finances. Again, it reinforced for us the idea that we needed to have a system in place which would enable people to plan. The people we met in those circumstances are in a minority. The majority of people have not entered into that world at the moment.

Q408 Rosie Cooper: Absolutely. Care villages are a great upcoming concept and there will be more of them, I am sure. For people with those kinds of choices, that will be great.

I asked the question to bring us back to a point made by Mr Dilnot. You said the state should only pay for the basic cost of care—we will call it a £35,000 cap, although probably, if it ever happens, it will be much higher than that—once you reach that £35,000 cap. Within the last year I have been with relatives around home after home. When you look at what a local authority is providing for £500 a week, you find that the actual costs to the home are much more, and the CQC—I have asked questions—measure against minimum standards. The reality is that, for that amount of money, quality is being driven down. Those people who can pay are cross-subsidising, being ripped off, and paying twice for the bit that the local authority is not paying. Once the £35,000 is reached, what we are saying is that it is not a cap; it is very, very porous. Then, if you want to be housed in anything other than the poorest, smelliest or whatever place, you are going to have to pay a lot more. I have heard stories where homes are costing £1,100. In my case, the family had to pay almost £1,000 a month in top-up. I will not go into it because it got really bad after that and went up and up.

When people hear you talk about £35,000 they stop listening because they think, “Ah, £35,000.”—when the truth is that they will pay more if they want to stay—“the state should meet that basic cost.” They are not hearing the bit about hotel costs and all those other things. We had a figure put to us that before the state would pay a penny—before you got any assistance—you would probably have to be in the system for two to two-and-a-half years. Is that how you see it?
Andrew Dilnot: How long you would have to be in the system before getting assistance would depend on how significant your needs were. It could be two to two-and-a-half years or a little more than one year. It depends entirely on what your assessed level of need is. I fully sympathise with your concern that, for any system to work appropriately, the quality of care deemed to be necessary by the state must be a quality of care that we all think is appropriate and respects the needs of people and what they can justly look forward to. It is certainly not the case that our recommendations are about driving that level down, but it is important for us to recognise that some people will want to make choices that go beyond that level. If people want to make choices which go beyond that level, then that is a choice we would expect them to pay for themselves. We would be very disappointed if the quality of the standard package of care and accommodation continued to be as poor as we certainly see available now in some local authorities. One of the many reasons why we need reform is to unlock all of this so that we get better quality.

As for what people understand at the moment, our sense—this is borne out by a lot of the research done for us and hundreds of conversations we had with individuals—is that people do not understand the system. They do not understand the system because it is almost never talked about. Why is it not talked about? It is complicated, but it is also a mess. Frankly, as either a local government politician or a central Government politician, if you are responsible for this,
it is unlikely you would want to talk about it very much because it is not something to be proud of.

One of our great hopes is that, once we have a decent new system in place we can start to feel proud of, people will begin to talk about it more and understand it better. Also, the reason it is not understood at the moment is that it is like a juggernaut coming at you. There is nothing you can do except cross your fingers and hope it does not happen to you. As a result, there is no discussion. People never make choices because they do not feel they have any control. Once there is a system where people can start to make some choices about what they want to do, we will build up skills and understanding about how the system works. That will take a while. Yes, it is not fully understood and our proposals are not as fully understood as we wish they were, but we have to do something. We are pretty sure that this is as good as we can do.

Q409 Valerie Vaz: Clearly, people have been thinking about it. It is why you were commissioned to do the report. All parties are thinking about having cross-party talks on what to do. People are thinking about it.

Andrew Dilnot: Yes, politicians are thinking about it but the level of understanding in the wider population is very poor.

Valerie Vaz: We are thinking about it because we are getting information from the wider population that something needs to be done.

Q410 Rosie Cooper: Having done the research you have done and looked at it out in the field and academically, can you say, if I was somebody wanting to go into this field, why I would open a residential home? Why would I want to get involved in this area, facing reducing costs, increasing pressures, a lack of skill-set among staff and delivering, against such a very low cost base, poor quality? Why would anybody want to get into it? If some people do not get into it, what is going to happen to us?

Andrew Dilnot: Why would you want to get into it? You would want there to be a new system. Under the current regime, one of the ways in which the system is not sustainable is that it is not a terribly attractive proposition, but the number of older people is rising very quickly and the overall level of our wealth, decade on decade, is also rising. This is something that we care deeply about. Most of us in this room will have had family members who have faced these kinds of challenges; that helps us to realise it is going to happen to us. We all know that this is something we want to be a part of. There is no question that demand is growing. That is the kind of thing that would tend to make a businesswoman or man want to be in that sector. The trouble is that the demand at the moment is ineffective because the funding regime is in such a muddle the demand does not turn into something. My response to you, if I were a businesswoman or businessman thinking of this, would be that I would jolly well want there to be some certainty and a reformed system. That is one of the reasons there has to be a reformed system. Otherwise, there is a risk that the supply of care will continue to decline, and the disaster facing all of us who have any responsibility for it will then be even bigger.

Lord Warner: Could I add something to help Rosie Cooper? I have talked to some of the people who are making decisions now about their future investments in residential and nursing home care. You have to remember about 40% of this market are self-payers. What they are going to do, unless we revise the system, is concentrate their efforts on self-payers. Many of your constituents will be left without some of these options. That is why, in terms of fairness and decency, as a civilised society we have to change the system. If we do not change the system, people will still invest in this sector but in a way which attracts self-payers.

Q411 Barbara Keeley: While we are on the point about fairness, you have talked about other aspects of fairness in your report—national eligibility setting and portable assessments—but is it not one of the great unfairnesses that informal care given by family members does not count towards that meter of care costs before reaching the cap? That is going to lead to all kinds of things—people pretending, perhaps, that they are worse than they are and people saying that they are not prepared to give that care. Why does not that crucial informal care given by 6.4 million people count in the system?

Andrew Dilnot: We certainly took the informal care very seriously, and I might turn to Jo in a moment to say a little more about this. That informal care is, as you say, the absolute backbone of the system. That is how families and care works and, without it, many millions of people would be bereft of care and in a terrible situation. We looked very hard at and talked at great length with organisations like Carers UK about what needed to be done. What they cared most about was the terrible lack of information and advice they find at the moment.

Perhaps the single issue where we do say something very explicit is the way in which carers’ assessments work at the moment. It is not our view that we could move to a world which was carer blind. People feel a responsibility to care for those closest to them and we have to recognise that in the system. If we move to a carer-blind system, it is too big a step for us. There are statutory assessments of carers that are meant to take into account the needs of the carers. At the moment, on many occasions, those occur many months after the assessment of the cared-for person and then nothing happens. We did feel very strongly, and one of our recommendations is that that needs to be tackled. Carers’ assessments need to be integrated into the assessment of the cared-for person and something needs to happen. Jo, is there any more you can add?

Dame Jo Williams: The only other point I would make, absolutely endorsing what Andrew has said, is about carers’ inability to plan as well. We believe that, if our recommendations are taken forward, it will not only enable the individual to do some planning but also the families. For instance, a family may feel that making some modifications to their own property is the right kind of investment, because they know what the state is prepared to do—using their assets, if they
have them, in a different way. Again, that was a message to us: "Take away some of the uncertainty as well as give us better information."

**Q412 Barbara Keeley:** I have a second point. You said earlier that the organisation which currently takes up the slack in the system is the NHS; if social care is not providing it, the NHS is. In many ways, though, it is not only the NHS, is it? The other part of the system that takes up the slack is the informal carer. I am sure the position of carers has got much worse because of the cuts. Even the NHS cuts, I think—the efficiency cuts, the £20 billion you talked about—will be affecting social care. For instance, in my area the NHS has ended a system of active case management for people with long-term conditions which means they are not being monitored and everything falls back on the GP and the family. Did you do modelling about the impact on carers of different aspects of the system and do you accept that the situation has probably got worse for carers since you did your work with them?

**Andrew Dilnot:** I will say a little and then turn to Norman to see if there is more he would like to add. Certainly one of the consequences of the ageing of the population, which, to me, is entirely welcome, and also of the longer lifetimes of working-age people with significant needs, which is also something we should celebrate, is that carers are bearing a heavier burden. There can be cases of working-age people with care needs who are now living long enough that there is a risk their parents may predecease them and that the parents will still have caring responsibilities as they themselves grow frail. As people are living longer and longer, at extreme old age, often, we will find that the care is being provided by somebody who herself or himself is pretty mature. It is also important to recognise that this is very much a women’s issue—the great bulk of care is provided by women. You are right to say that this informal care has been the other part of taking up the slack in the system. As the population has aged and we have more and more people with care needs, it is informal care that has taken up a large part of that burden. That group of informal carers is very hard hit by the open-ended nature of the current system. In many ways we would love to suggest more, but by at least taking away the fear of this tail-end experience we would make a significant difference to the experience of carers.

**Lord Warner:** You are quite right. I should have included carers as taking up the slack in the system, which is absolutely right. Pages 51 to 55 of the report very much reflect what the carers’ representatives said to us. We have reflected very much their priorities and their concerns in this report. What they consistently said they wanted was a proper recognition of their needs in the assessment of those needs and for that to be done at the same time, but separately, from the person being cared for. That was an absolutely key issue.

The other thing which they majored on very strongly, which is in our report, is the issue of carers who are themselves working. They saw the attitude of employers, as much as anything, as a big issue in their ability to cope. We have tried to reflect in this report what the carers’ representatives were saying. I have heard nothing contrary since then, and I am still in touch with the carers’ representatives. I was a trustee of Carers National Association, which dates me a bit. I have not heard them saying that our report does not reflect their concerns—what they wanted to get across to the Commission.

**Q413 Chris Skidmore:** I want to turn to who you might consider to be the beneficiaries of the report. There is a graph in the report looking at the net expenditure by income quintile. I know, Andrew, you have said the proposals are highly progressive, but there are alternative arguments which have said that the report would, in fact, be regressive as the bulk of new money would benefit the top two income quintiles. In particular, we have heard evidence from United for All Ages who have been quite outspoken in saying that “the cap”—£35,000—is “regressive”—everyone (except those below the proposed assets threshold) would be required to find the same amount of money regardless of their wealth. This could be seen as a care ‘poll tax’ for the so-called squeezed middle.”

Perhaps, more worryingly for yourself—you probably read it in the *Health Service Journal* on 26th October 2011—the Secretary of State is said to have labelled the proposals “regressive” himself at a private meeting with representatives from local government in October this year. What comments would you have for any critics of the report who would say that you are, in effect, penalising the squeezed middle and that this report will only benefit the upper middle classes?

**Andrew Dilnot:** There are a number of things. First of all, is it regressive or not? At one level, it is true that with any change from an entirely means-tested system, which is where we are at the moment, it is necessarily the case that a disproportionate amount of any spend will not go to those on the very lowest levels of income. If we had an entirely means-tested health service and we moved to a health service where everybody was entitled to care, that could be characterised as regressive at one level, but I do not believe anybody would think that was a sensible way of characterising it. We would say it was a way of helping people who had high care needs. We are proposing a way of helping people with high social care needs. Is it a way of hitting the squeezed middle? That seems to me to be simply incorrect. I am sure that is your own view as well. I do not know whether you have the second volume of our report in front of you—some of you probably do not—but there is a chart on page 27 of the second volume which shows, for different levels of the wealth distribution, who benefits most. It shows that the group most benefited by this is the group at the median of the wealth distribution. It is in the bottom half of the wealth distribution that most difference is made. At the moment, the person from the bottom one-twentieth of the wealth distribution loses 75% of all her assets if she needs to go into care. The bottom one-twentieth of our society loses practically all of the assets she has ever built up. That is somebody with wealth of only £70,000. The people who are really hard hit by
the current system are the bottom half of the wealth distribution for whom the prospect is that, if they are unlucky enough to end up in the tail end of this risk distribution, they lose all economic control. Some people have said to me, “That simply means you are proposing a scheme to protect people’s inheritances.” Again, you could characterise the NHS as a scheme for protecting people’s inheritances because, in the absence of the NHS, if you had a serious healthcare problem you would certainly not have any money to leave, but that is not what it is doing. If you want to tax inheritances more effectively, by all means do it, but do not do it for the one person in 10 who ends up having to have social care needs met.

The important point to make is that the beginning of a care journey is not death. Many people begin a care journey and then have fruitful lives for many years. We want them to have some chance of economic control and stewardship over their own life then. It is very important that we have a system where there is a way of planning and a way of managing your resources. We feel strongly that this is not about helping the wealthiest. Of course, it is true that if you were a very wealthy person and you had an extraordinarily long period in residential care you would benefit from it. Most people do not. What we are doing is taking away fear. The story we heard again and again as we spoke to people was of fear—the fear of losing everything, which paralysed them again and again as we spoke to people. The story we heard was of fear—of the fear of losing everything, which paralysed them from taking any action.

I am pretty robust in saying, no, it is not regressive. Anyway, it does not make sense to talk about progressivity or regressivity without thinking about where the money might come from. That was not our job, but I am sure that any way the Government finds where the money might come from. That was not our job, but I am sure that any way the Government finds the money for this would, overall, be net progressive.

Q414 Chris Skidmore: Taking it from the other end, are you worried about people gaming the system if you raise the cap to £100,000? A lot of people—my constituents—come to me in various degrees of frustration saying, “I might as well just piss it all up against the wall.” Basically, if you go underneath that cap, it is all prepared for you. With raising the threshold so high, is there not a danger that you are doing is taking away fear. The story we heard again and again as we spoke to people was of fear—the fear of losing everything, which paralysed them from taking any action.

I am pretty robust in saying, no, it is not regressive. Anyway, it does not make sense to talk about progressivity or regressivity without thinking about where the money might come from. That was not our job, but I am sure that any way the Government finds the money for this would, overall, be net progressive.

Q415 Chris Skidmore: That is quite similar to the deferred payment scheme that local authorities might offer.

Andrew Dilnot: No, the deferred payment scheme would still be a payment scheme. This is a way of alienating the asset and escaping altogether. This is an encouragement to cheat. Cheating is always wrong—always wrong—but a system that provides so massive an incentive to cheat is a bad system. One of the things that putting a cap in place does is to massively reduce the potential gain from cheating—from, at the moment, all of your assets to whatever the level of the cap is. Gaming is always a worry but, by putting a cap in place, we would massively reduce the incentive to cheat. Coincidentally, that is one of the ways in which the costing of our proposals was probably unduly conservative. We did not assume any reduction in gaming and I think there will be a very significant reduction in gaming. There is something puzzling about the statistics. There appear to be not enough self-funders. More people than we would expect end up passing the means test, which suggests there is something funny going on.

Q416 Chris Skidmore: This is a separate point on the modelling you have done. What account did you take of levels of dementia rising?

Andrew Dilnot: We took the standard assumptions—I cannot remember the precise numbers—so a significant increase in that, but neither accelerating nor decelerating. Certainly, one of the groups that we hope would be particularly helped by the production of the cap would be those with advanced and rapid-onset dementia. I have here a note from one of my colleagues. We assumed that the age profile prevalence was unchanged overall, but the big increase in dementia will come through the ageing of the population.

Q417 Valerie Vaz: My colleague mentioned the Secretary of State. What discussions have you had with either him or the Department of Health about how you are going to progress your report?

Andrew Dilnot: I have had extensive discussions over 18 months with members of the Government and with members of the main Opposition party and their advisers through the whole period, both before and afterwards. There are nascent cross-party talks going on. I continue to be involved in discussions with all those players.

Q418 Valerie Vaz: What is the Government saying about your report and whether it will be implemented?

Andrew Dilnot: The Government is saying that it has set up a consultation process, which finished on Friday last week. There will be a report back from the six strands of that. I imagine that will now be early next year rather than before Christmas. They have said there will be a White Paper and a report on progress on funding by either Easter or April. I cannot remember which.
Q419 Chair: It is spring, is it not—an elastic concept?
Andrew Dilnot: I am pretty sure that I have been told that it will be by April, certainly by the end of April. There were some who said, “Are you not a bit frustrated? You have spent a year doing a consultation?” My response is, “No. It is an independent commission.” We have done a consultation and it is perfectly reasonable for the Government to check that what we say is what other people think. It seems to me to have given space for the stakeholder community to come out with an unprecedented degree of consensus—a degree of consensus we have not seen before.

Q420 Valerie Vaz: Was that your expectation when you did the report? Clearly something needed to be done and you spent a lot of time on it. How much has it cost altogether?
Andrew Dilnot: As to the report, I do not know the answer to that. We could get you a note. I think it is significantly less than the budget set for it. The budget was something like £3 million. It is a great deal less than that. We expected, by the time we got to the end of our report, that there would be consensus because, throughout the report, Norman, Jo and I consulted with many people in this room but also the stakeholders.

Q421 Valerie Vaz: Are you surprised about the “noises off” from the Secretary of State?
Andrew Dilnot: All I have seen is that the Secretary of State was reported as saying it was regressive. He has not said such a thing to me nor has he said it on the record, and I do not imagine that is—

Q422 Valerie Vaz: It is never on the record.
Andrew Dilnot: The responses I have had—and I will now be a little more explicit—from all the politicians with whom I have spoken across all parties have been positive. There is a widespread acceptance that this is an area which is something of an embarrassment to us as a society. It is an area where we are letting ourselves and other people down and there is a real desire to get a way forward that has some cross-party consensus. We are not naive. We realise how difficult that is. We also realise that the public finances are in a more difficult position than at any time in the last 30 years. On that, one thing I would say is that the costs that have been much talked about—the £1.7 billion a year—are what it would be costing now if it had been fully implemented. The amounts of money we are talking about in this Parliament, by the time it is implemented and starts running, will be in the low hundreds of millions of pounds. Our own view, repeated, is that £1.7 billion—0.14% of GDP—is a small sum of money relative to the overall activity of Government. It is not a small sum of money, but it is about one-four-hundredth of what Government does. Our view is that this is more important than that. Therefore, although it is difficult to work out precisely where the money might come from and how it would be introduced, it is a significant enough change which, in our view, would make a real step forward and allow the kind of partnership that we have not seen before, that all parties should try and come together.

Q423 Valerie Vaz: To draw down into the mindset of all three of you when you were producing the report, did you have in mind all the evidence or did you think, “This is going to be a pragmatic report. We want it accepted because this is the way forward”?
Andrew Dilnot: I think both. If we had felt that the right way forward was a way that would not have been implemented, we would have said so. We really would have said so. It is not the case that we have been grubbily pragmatic. We believe that the key elements of going forward are: we have to tackle the fear, which means tackling the tail-end risk; we have to come up with a partnership; we have to tackle the poorest, which is why we argue for a significant increase in the upper assets threshold in the means test from £23,500 to £100,000; we have to tackle information and advice; and we have to tackle the role of carers. I do not think that, in any area, we have stepped back from things that we passionately believe.

We recognise there are trade-offs to be made about the levels in all of these cases but we genuinely believe—certainly, I genuinely believe—that this is the right methodology, a framework that combines individual and state provision, where the state is tackling the vulnerability that we all face and where we get a way of respecting carers and delivering information and advice. Although there is pragmatism in the detail, at the general level we were horribly principled.

Q424 Barbara Keeley: Before we leave your role—and I understand you will be busy elsewhere in the House later looking at a new role—you have done an awful lot of presentations and meetings. I think I heard you say last week that it was 40 meetings at which you had spoken about your recommendations. All-party groups here in the House have suggested that there be a continuing role for you and the Commissioners and that you needed a secretariat. There need to be some resources behind this. There is a question of how we get and keep a debate going which is quite a bit later than your original recommendations. If you are now moving off—and best of all, your appointment—how on earth are we to keep a debate going that is only just, in effect, starting?

Lord Warner: Could I help the Committee? We do need to keep speaking and we are doing so on this. In a spirit of helpfulness to the Government, I and a number of Cross Benchers have put an amendment down to the Health and Social Care Bill to be debated in Committee tomorrow which would give the Government powers to implement this, among other things, using the affirmative procedure. If the Government does have an appetite, having now completed its consultation, it would be possible for it to take this away for the Report stage and come back with proposals. I suspect and would hope that across the parties—across the benches—there would be some support for taking powers in the current Bill, which is, after all, a Health and Social Care Bill, for progressing this, but it does depend on cross-party
support. It would need all the parties to be willing to take the step of giving the Government powers to make regulations which would deal with all the assessment issues, the eligibility issues, the charging issues and so forth. There is an opportunity to progress this, using the current Bill, if there is sufficient political appetite.

Chris Skidmore: The time scale—
Chair: If this were the BBC, I would congratulate you for getting your plug in.

Andrew Dilnot: In response to Barbara Keeley’s point, it is possible that I may be moving on to do something else but I have made it clear in those discussions that I would not be willing to start doing that until April, because I am committed, until the White Paper is produced, to continuing to spend a great deal of my time on this, as I have since the Commission finished. Like Norman and Jo, I really, really, really care about this.

Chair: Thank you.

Q425 Dr Sarah Wollaston: I have a very short question. To what extent do you think direct payments solve a number of problems that would be a cause of difficulty? I am thinking of things like the difficulty of metering care costs, the difficulties that carers face not having their contribution recognised, the problem that you touched on earlier about money being allocated to local authorities but not reaching social care, and even issues like fairness within the system. How does an inner-city metropolitan area benefit relative to an area like Surrey where, obviously, the care costs are somewhat different? How hopeful are you that that would be introduced and be helpful?

Dame Jo Williams: The point about the personalised budget is that it potentially gives people more choice. But in accessing those budgets they are still going through the current system with all its limitations we have talked about this morning. Potentially, it enables people to think more carefully about how they might make arrangements themselves to stay at home, possibly using family carers to do that, so there is more flexibility. I do not think it addresses the fundamental question we tried to address in our recommendations: what is the contribution of the state and what is the contribution of the individual as we go forward? As a mechanism for helping people live the life they want to lead, it has many advantages, but it does not address the funding issues.

Q426 Dr Sarah Wollaston: Can I stay with you, Dame Jo? One of the aspects you touched on in your report was better information for carers. Obviously with your CQC hat on at the same time, can you say what progress is being made in delivering genuinely good information? It is dreadful, as you say.

Dame Jo Williams: From the point of view of the CQC, we now have a website which gives more information. If this were the BBC, I would congratulate you for getting your plug in.

Q427 Dr Sarah Wollaston: As I understand it, organisations like Help the Aged were backing things like the HSBC policies. Who should undertake that? Who should be giving them the seal of respectability?

Andrew Dilnot: That is a tricky question. One particular set of issues does relate to financial services products and there we recommended, and have already initiated as a result of our report, Financial Services Authority involvement. As these proposals go through, the FSA’s involvement in trying to work out how best to make this work is very important. Part of the problem is that too often, because of the vulnerability, in the sense of risk, people do not get to thinking about this until they are in crisis, and that is almost always too late. It would be interesting to consider the idea that the point of retirement is a point at which it is possible to trigger information and advice. That is a time when people might start thinking about it but they are not yet in a crisis. The worst possible time to be thinking about financial products is when you are faced with a traumatic care need in your own family. Finding trigger points that are not care triggered may be a way forward.

Q428 Chair: Before I bring Dan in, I have a related question which goes back to some of the things you were saying about the importance of a national care assessment in order to provide greater clarity in the system, to facilitate portability and to facilitate greater personalisation of care. All of those are familiar arguments for a national care assessment. I wonder whether this is leading social care back to where it came from, which is a branch of social security, and whether you think that is a good thing or a bad thing. It is perhaps worth asking you whether we should also reflect on the reasons that led to social care—care of the elderly—being moved out of the social security system. Are we heading back to a world we came from without adequately taking account of the risks that come with it?

Andrew Dilnot: That is a very interesting point. It is the case that there are many characteristics of social care—particularly for older people—that look like
characteristics of the social security system. Take the old age pension. The state provides some help for people as they age but also expects people to provide help for themselves because ageing is a predictable event. Most of us are going to age and most of us are going to have care needs. In fact, the principal line behind why, in the end, we think it is reasonable to expect people to make some contribution in the first slab is that most of us can expect it. That looks like an expectation that is nationwide.

The way in which social care became local authority led—almost as the last vestige of the Poor Law, though not in the pejorative sense—does seem slightly out of place. Our recommendations are indeed moving towards seeing this as a national responsibility, as something where the state has a role, and it needs to be clear what the balance is between the state's role and the individual's role. In many ways, that does look rather more like a social security-type structure. Are there anxieties that come along with that? One anxiety is moving away from so much localvariability, but that seems to be something that, by and large, the population is keen to do. Other than that, I do not see—

Q429 Chair: To remind ourselves of one of the reasons why, in the early 1990s, a substantial part of this budget was moved out of social security into local authority management, it increasingly became a definition of entitlement, and there was a sense that the result was not a system that led to proper prioritisation in the use of resources or, indeed, proper manageability of the total quantum of resources involved.

Lord Warner: Could I respond on that? I was the senior civil servant in the then Department of Health and Social Security who had to deal with what happened to the social security system in that period. Almost by accident, social security got involved in this system because people were claiming benefits for their residential and nursing home care. It was finally spotted that that budget was growing extremely rapidly. Indeed, you could argue that the social security system largely financed the birth of a nursing home sector in this country. In order to ensure you did not skew the total system too far towards residential and nursing home care but could balance the system more towards out-of-institution care, there was a gradual move back to local authority responsibility. This, in fact, led to a growth in home care. We then saw the growth of the domiciliary care sector coming out of the traditional home help service, which had always been a local government service. There had always been a part of this service which was earthed in social services.

Could I mention something which has not had a lot of attention? We did look at what other countries were doing and one of the interesting things I have in my head is a seminar we had on that. It was, I think, the PSSRU who did the work on this. One of the things they found—I have Spain in my head as the example—was that the state was making an offer of care support but also saying that if people wanted to take the cash and look after themselves, in effect a personal budget, it would offer them less than the total cost of the care that the state would provide to help people personalise the care packages they wanted. What seemed to have surprised some of these governments, particularly in Spain, was the extent to which people took the money rather than the care package provided by the state, even though the value was, in some senses, quite a lot less. So there are some things going on in other countries as they wrestle with this issue of the demographics and what part the state, in some kind of partnership with the citizenry, should play in coping with that. There were some very interesting things we found which came out of that.

Q430 Chris Skidmore: You did not make any recommendations about incentivising families to take a greater role in the care of an elderly relative within the report. That would be a classic example of how you could do so. One other idea, off the top of my head, would be for a local authority to suspend council tax for the family caring for someone else. It would be an easy way in which you would be able to achieve a greater responsibility within a family to look after their relative.

Q431 Valerie Vaz: I am not getting into a debate on this now, but the societies are slightly different. They are much more in favour of an extended family in Spain and they do not have a history of social care, do they?

Lord Warner: I am not arguing that we should do that.

Q432 Valerie Vaz: No, but we have different starting points, don’t we?

Lord Warner: The point is that these different countries are wrestling with this issue about what is the right balance between the individual and the state in order to provide a care and support system in old age. Nobody has a silver bullet. Nobody has a perfect solution which is going to crack that. We have, in our proposals, to some extent moved down the road Mr Skidmore is suggesting. The national equity release scheme that we have suggested does make it easier for the citizen to pay you some of the accumulated assets to fund, admittedly retrospectively, the care that they have consumed. There is nothing in our report which demolishes the argument for more personal budgets, but it is very difficult to see personal budgets being the solution unless you increase the pot of money available. In a sense, you cannot have your expansion of personal care budgets with help from the state unless we can increase the pot.

Q433 Chair: The dilemma here, surely, is that if you allow the conversion of a care assessment into a cash sum at full value, you will almost certainly have increased the cost of the total system.

Lord Warner: Yes, sure.

Q434 Chair: Whereas if you apply the Spanish principle of converting the care package into a reduced cash sum, that will create a very strong negative reaction. Given that dilemma on cash conversion, is it not an implication of a national care assessment that we are going straight into that dilemma with our eyes shut? That is my question.
Lord Warner: I suspect it depends on a political judgment about where people stand on the issue of choice and people’s ability to make sensible judgments about their own needs. As an unconstructed supporter of choice, I think people ought to be able to have the chance to make some of those judgments themselves where they feel able to do so, without forcing them to do so.

Chair: I leave the question in the air a little bit.

Q435 Rosie Cooper: I do not think people understand that until they experience imposed state or care services which are too rigid and dreadful.

Q436 Dr Poulter: I have a couple of questions. First of all, Lord Warner made the comment about pots of money. If the Government were to support your proposals and invested £2 billion or £3 billion into the system—or £1.7 billion, depending on where the cap is set—can you clearly articulate what benefit or additional resource this would bring to the system? What additionally would the Government’s investment bring to the current system and how would that support your proposals?

Andrew Dilnot: The immediate impact would be a taking away of fear. The day one effect would be that people who, at the moment, are terrified by this prospect would no longer be terrified by it. The day two effect would be that people would start spending money which, until now, they have held off from spending because they have been so frightened they might end up in the tail end of this distribution. I think we would see greater spending on prevention and adaptation. We would then quite quickly see a development of a wider range of forms of care provision, and alongside that we would see greater choice and the slow and steady development of a financial services market. The immediate impact would be that people would stop being frightened and, as a result there would be more spending. As a result of more spending, there would be greater diversity, higher quality and better care, which seem to me precisely the things we most desperately need.

Q437 Dr Poulter: Do you think that that investment by Government of £2 billion or £3 billion—whatever the sum is, depending on whether your proposals are implemented and what the cap was set at—would be enough to address this big funding gap we have been talking about in terms of adequately providing for adult social care, particularly looking after the elderly?

Andrew Dilnot: It is not an answer to the unmet need in the current means-tested system. There is a range of people at the moment who would pass the means test but are not eligible for any care because of the constraint. Unless something is done about that system, that problem would still be there. In the short, medium and long term, this would significantly reduce the amount of unmet need, but changing the funding regime will not tackle the problem of the current unmet need, which is a problem of an underfunded means-tested regime.

Q438 Dr Poulter: In response to my earlier questions about improved integration, Lord Warner was right to make the point that this has been often talked about but what it means has not been pinned down. Drawing on examples where there is better integration of social services care with NHS care, breaking down the funding silos that exist—I am presuming from the other parts of your report—has to be an essential part of dealing with the funding gap.

Andrew Dilnot: At the moment, we are certainly not efficiently using the money that is being spent. If we could get better integration we could move a long way forward. That requires other structural changes within the NHS and social care system that are not strictly about funding; it is certainly something that we quite explicitly support—it is one of our recommendations—and is vital to getting the best use of the funds.

Q439 Dr Poulter: I have one last question for you, and then, please excuse me, I have to go to a meeting at the Department of Health. You have talked—this is a key point—about the almost perverse incentives that exist in the current system. We have spoken already about the fact that the current system is financially not sustainable. That is generally the view. One of the perverse incentives in place, for example, is the drive by local authorities to put people in residential care because of their ability to take and utilise some people’s assets as a way of paying for that. Clearly, what we are saying is that, financially, the current system is a broken system and we have to have a long-term funding solution. In terms of how the system operates, both in terms of integrated care and of the drivers in the system—not drivers that are necessarily for the benefit of people but financial drivers; the two can often be very distinct—would you say that your proposals help to reduce and remove some of these perverse incentives? That is certainly my view. I wonder if you might be able to comment.

Andrew Dilnot: Absolutely. That was one of the objects we had in mind. We all know that any system has unintended consequences and that there will be incentives for goodness knows what, but when we looked at the current system, we thought, “This does look a muddle. Let us try to identify some of the worst of those perverse incentives and remove them.” I am sure there are some we have missed and probably some we would create, but on the whole our sense is that if we got something like this we would radically reduce that. One example is the nonsense of the current means test where wealthy people are encouraged to cheat, at great cost to the state and huge cost to public morale. Yes, we thought that very important and we hope it will make a difference.

Q440 Rosie Cooper: Following on from that, and almost going back to the beginning, you signalled your intention to look at the totality of public spending on older people. I would like to ask you what the Government reaction to that was and did the Government make suggestions as to the scope of your review?

Andrew Dilnot: Our terms of reference are pretty clear: the funding system for care and support. The
health service, the social security system, essentially, is outside our remit. In our early response to the Comprehensive Spending Review, I made it very plain that it made no sense to think about this divorced from everything else. We did not think about it divorced from everything else. We did not attempt to make recommendations about how the structure of the Health Service funding regime works, although we did make it clear that we thought further integration was important. We did discuss the role of the social security system and, in particular, the benefits for people with disabilities. So we did think about it in the round, although our core recommendations are about the social care end of the system.

Q441 Rosie Cooper: Did the Government limit your scope?

Andrew Dilnot: At no point did the Government attempt to put any pressure on us. When I was asked to take this on, I said I was delighted to take it on. I knew that the Government was looking for an independent report. One of the reasons I knew that was that they knew that if any attempt was made to put any pressure on me, I would go back to my day job. At no point was there any suggestion of any such pressure and nor has there been from any of the political parties. We did not feel limited. We only had a year and our sense was that, although it would have been possible to widen the scope to look in more detail, for example, at integration between health and social care, it was a job for another place. There was enough of a muddle in the funding regime for care and support for us to know that if we could come up with what we thought was the right essential model—which is a partnership, with the tail-end risk removed—we would be doing our job.

Q442 Rosie Cooper: I do congratulate you on your report, but for somebody like me there are so many real definitive cross-over areas. Lord Warner talked about the opaqueness of continuing care assessments. That is fundamental to all of this and yet my guess is that you would not have discussed it.

Andrew Dilnot: We discussed it.

Dame Jo Williams: We did.

Andrew Dilnot: You have no idea how much discussion there was. We have looked at the decision tool. We did discuss many of these issues which might be thought of as peripheral, not in the sense of being less important but as being on the boundaries. What we have tried to do in all of them—continuing care is an example—is make sure that our core recommendations are consistent with what we think should be the sensible direction of travel and that, where possible, they reduce some of the problems. Take the problem of continuing care. Many people who end up going through that process are people who, once there is a cap in place, would already be beyond the cap. That horrible process which can be so distressing and time-consuming would no longer be necessary for them. For some people, such as those who have an acute problem, it could still be necessary. We had lengthy discussions about it. In the end, we restricted ourselves to recommendations about our core areas of concern while trying to make sure that we took into account as many as possible of these other issues.

Q443 Rosie Cooper: If you had comments and the results of that discussion and you could pass them back to the Department of Health, that would, in my view, be very useful. I was horrified when I saw that system close up. A lady who was incontinent, not able to feed herself and not able to talk was having to be discharged from a hospital to a nursing home as she was not deemed to be in need of continuing care. She died within five days. The family were told that, because they were in the room, they had taken part in that discussion, whereas in fact what the Knowsley social workers did at Whiston hospital was speak, tick a lot of boxes and say, “No, she does not meet the criteria. Away you go. Fund this.” When I heard about it I said, “Get a copy.” They were told, “No, you cannot have a copy of the questions and answers.” When they said, “We will apply for it using Freedom of Information,” they said, “No, you cannot,” and, because she died so soon thereafter, it never took place. Families out and about the length of this country are being treated like that. Any comments that you had and could feed back to the Department of Health and the social services departments would be very useful methinks.

Lord Warner: We have made it pretty clear that if you go along the route we have proposed in this report, you have to have a national system for eligibility criteria for adult social care. It then follows that you have to do something about how that butts up against the continuing care system assessment. There is no escape. I am quite sure the Department of Health will find this a difficult issue to wrestle with. I am absolutely confident that they are finding it a difficult issue to wrestle with. I do not think you can have our system without having greater consistency and more openness about the way continuing care is assessed for individuals. Where we are heading now, if we do nothing, is that local authorities will be increasingly concentrating, under the FACS system, on those with critical care needs. They are the very people who overlap with the continuing care assessments.

Q444 Chris Skidmore: May I return quickly to the potential for creating, as you say in your report, space for new financial products? I was quite encouraged by what you were saying. Andrew, about having conversations with various insurance companies. Our experience in the Committee in the past few weeks has been that a couple of people have said there is not an enthusiasm from insurers to create new products. Obviously, there are various schemes already around such as immediate needs annuities, but only about a thousand a year and there are many supply-side barriers anyway to creating those products. With immediate needs annuities, given that they cost around £100,000—we were told by Partnership Insurance when they gave oral evidence to the Committee that, under your proposals, that cost is only likely to reduce by about 5% to 10%—there is still going to be a huge element whereby people prefer to take that risk you were talking about rather than actually invest for the future.
Andrew Dilnot: I have read the uncorrected transcript of that session. Immediate needs annuities are a good thing. The way of thinking about an immediate needs annuity is as though it is the only insurance product available for your car and it is in the split second before you have a car crash that you get the opportunity to share your risk with everyone else who is having a crash at the same time. We would prefer that to nothing, but it is not very attractive. I have no doubt at all, having spoken to the really big players in the financial services sector at the highest and most senior level throughout this, that there is enthusiasm for getting into this market. The financial services strand of the Department of Health’s consultation on this has already published some of its developing findings. It says things like, “There is strong support for capping care costs”—This would provide a major opportunity for behaviour change—and, “It would facilitate a range of financial products.” That is across the financial services sector as a whole. In your evidence session you had evidence from the Association of British Insurers, who I read as being extremely enthusiastic, and you had evidence from Mr Horlick who works at Partnership, which is an important part of the extremely small niche market that exists at the moment. Our view is that there would be very significant development in two areas, mainly housing-related and pension-related, because those are the two big assets that people build up. For many people, once a cap is in place they will simply treat the funding up to the cap as part of their general asset accumulation strategy. They will want to build up some assets that they might use to help out one of their children, go on a long holiday, build an extension or do the things they have wanted to do. Rather than wanting an insurance product, it will be part of their lifetime savings strategy. They might then spend that money through either equity release from their house or by a policy that was related to their pension. The natural way of doing it through your pension would be to see the creation of a thing called a disability-linked annuity rather than taking a flat annuity. Say you had a pension pot that would give you a pension of £10,000: rather than taking a pension of £10,000 a year you would take a pension of £9,000 a year and that would then treble to £27,000 a year if you had a social care need. That works because these risks are negatively correlated. In general, on average, once you have a social care need you are likely to die sooner rather than later. I have no doubt that the financial services sector is willing and interested to do this. The reason they are willing and interested to do this is that the number of us getting into this area is growing all of the time, average levels of income and wealth are growing and, at the moment, they are not able to get involved in this market because there is nothing they can do.

Q445 Chris Skidmore: You also recommended that a duty should be placed on local authorities to offer deferred payment schemes, and, obviously, they can charge interest to make those cost-neutral. If I could take up this local authority proposal for a deferred payment scheme, what would be the point of an equity release product? Why would I get involved in that? Does it not act as a disincentive?

Andrew Dilnot: It might do, but you might prefer to deal with all of your liabilities before you died. That is certainly perfectly possible. I also think we need to focus on what people will do that they do not do at the moment. The biggest problem in social care is that almost all social care needs are only tackled once they become acute. People do not make adaptations early on or move to appropriate housing; they do not put in hand rails, stair lifts and downstairs loos, and the reason they do not do that is because of the downside risk—they might end up with a large liability. That is our strongest sense of the behaviour change that is potentially exciting and might have a big impact on the health service. One of the things people tend to forget until they work in this area is that the health service is, by and large, about looking after older people. Our hospitals are filled with people who, in many cases, if there had been sensible social care interventions early on, would not have ended up there. Those are the kinds of changes that we think could be very important.

Q446 Chris Skidmore: But while the NHS is still there to pick up the tab, you could simply say, “Go off and leave it.” There is no sense in which—

Andrew Dilnot: People do not want to fall down the stairs. People want to be healthy. As an economist thinking about incentives, you need to divide things into where you are worried about incentives and things where you are not. I am not worried about people having an incentive to be healthy; people have an inherent incentive to be healthy. At the moment there is a huge financial difficulty which prevents them doing that.

Q447 Chris Skidmore: I would contrast that against the rising levels of type 2 diabetes which will take up 25% of the NHS budget—it is 11% now. Surely, these are demographics which go against that argument. Andrew Dilnot: I am not saying that everybody is well controlled. I am saying that, when I am thinking about incentives, if I am worried about incentives that might encourage people to do something financially good for them, I am always very worried about financial incentives. People want to be healthy. If we create a world that makes it easier for them to make choices that will help them to be healthy—of course some people will still make unhealthy choices—more people will do that. The kind of system we are proposing will lead to more prevention and adaptation.

Lord Warner: If we want to carry on putting people aged over 80 in the medical wards of acute hospitals at £3,000 a week, we should do nothing about the adult social care system. We can carry on doing that, which is an option for us. Or we can do something which would provide a cheaper alternative in adult social care, something which people prefer. People are not queuing up to be admitted to NHS hospitals. We have options, as a country, to do something different.

Q448 Chris Skidmore: Finishing on a point of process—and this is more of a political point as well...
strategy is to change the rules of public sector support. It is fair to say, is it not, that your time—see in the Health Service Journal, Andrew, you are quoted as saying, “Will it happen? I think there is an eight out of 10 chance.” You agree with that comment. You mentioned a trade-off of levels. Is this essentially going to come down to where the cap is set? You may not want to answer this, but you have said £35,000. At what point would you think it is unacceptably high? Would you be happy with £50,000 or would you be happy with £60,000? To what extent would you say, “The model I proposed will no longer have the desired effect if it is raised too high”?

Andrew Dilnot: It is an entirely appropriate and fair question. In our report we used the number £35,000, but in the detailed workings of our report we say that we think the number should be between £25,000 and £50,000 a year in current-day terms. The reason we fixed on £50,000 as the level beyond which we thought it should not go at the moment was this. If you go much beyond that it is important to remember there are many parts of the country where that is a plausible level of housing wealth for a single elderly widower or widow. If you go much beyond that, you are not capping the risk effectively. It is an individual thing, so you have to double it for couples. Our feeling is that much beyond £50,000 would not work.

The financial services industry, in its consultation, has talked about a figure of between £50,000 and £60,000 by implementation. Those are figures that are not in any way unreasonable. If it goes much beyond that, then it is not something that would mean enough to the population as a whole. If it did not mean much to the population as a whole, we would not get innovation in the financial services industry. Of course, in general, I would like to see it lower rather than higher because of the concerns about progressivity. The higher it is, the less help you are giving to the person on the lowest levels of wealth. That is the argument going the other way. That is why we thought something of the order of £25,000 to £50,000 or so. I do not think any of us would die in a ditch about a particular number, but I would, for example, say that if the cap got up to £100,000, that would not do the job. That is what the financial services industry is saying as well. If you go a little above £50,000, because there will be a bit of inflation anyway before this gets implemented, that is the kind of level that seemed to us to make sense. We talked about this with the financial services industry, with the whole stakeholder community, with all of the charities and with individuals, and that seems to us about the right sum of money.

Q449 Chair: It is fair to say, is it not, that your strategy is to change the rules of public sector support to this sector in the belief that that will produce a private sector response? Did you consider at all making the changes to the public sector rules conditional on some private or individual response?

Andrew Dilnot: We certainly talked that through, and that is something which has been discussed in other countries. Indeed, you could categorise some of what has happened in the US—or, in the end, not happened in the US in the CLASS Act—as trying to go down that road. In the end, our feeling was that this is something that affects all of us. We all face this prospect. It is simply wrong that this should be the one area where there is un pooled risk. After lengthy consideration, our view was that the pooling of this tail-end risk is something that the private sector will not do. It is not unreasonable for the private sector financial services industry to say they will not do it. For you and me, Chairman, I hope that, on average, it will be at least 30 years before we might need such care. That is too far away to ask the financial services industry to give us a fixed premium. We cannot insure our houses and cars for 30 years from now. There is no way they can take that risk. Laying it off to the private sector is not going to work. This is an example of something where only the whole community—in this case represented through the state—can take action. In principle, that could have been done through, I suppose, a compulsory impost. In the end, that is what the state doing it would be.

Q450 Chair: Compulsion is one way, but another is to say that there is one set of entitlement rules for people who have taken certain actions and another set of entitlement rules for those who have not.

Andrew Dilnot: Sure. I can see that possibility. Part of what one has to face in all of this is that one needs to think about three groups. There is the age group facing the prospect of the need for care now. There is very little that that group can do about it. Then there is the group that is retired and is planning. Then there is the group before retirement. It seems to me that the group that has not yet retired is the group where one might think about such actions. I do not think we would rule out the possibility that there might even be auto-enrolment into something that might encourage such action once the NEST scheme has got itself underway. But that is in decades and a long way away from having an impact. In terms of the current system, it seemed to us that, for those who already faced the prospect for the need for care or those who are retired, we have to act.

Chair: Do we have any other questions? No. You have been going for well over two hours, and it has been a very interesting and useful session. Thank you for your time.
Tuesday 10 January 2012

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Barbara Keeley
Grahame M. Morris
Dr Daniel Poulter
Mr Virendra Sharma
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Liz Fenton, Chief Executive, Princess Royal Trust for Carers, and Emily Holzhausen, Director of Policy and Public Affairs, Carers UK, gave evidence.

Q451 Chair: Good morning. I am sorry to keep you waiting; it is our first meeting since Christmas, and there were one or two things that the Committee wanted to talk about before we moved into an evidence session this morning. Could I ask you to open the session by introducing yourselves, and also by telling us a little about the role of your organisations in carer support in the social care context?

Emily Holzhausen: I am Emily Holzhausen. I am Director of Policy and Public Affairs at Carers UK. We are an organisation of carers and chaired by carers. We provide a lot of support and advice to carers—we run an information and advice line—and we have been campaigning for change for the past 40 years, from when a woman gave up work in order to care and found that there was no support available whatsoever.

We have a local network of around 55 local branches which are entirely volunteer run, so we have a very strong volunteer base, and we have an affiliate network of around 400 local organisations across England, Wales, Scotland and Northern Ireland. Our job of work is really to be the voice of carers, which comes very strongly through our membership. We must not forget that families who provide unpaid support are really the backbone of care in the community to the tune—I am sure you have seen our report, but I will give a figure to you. We warmly welcome this inquiry and very much look forward to hearing the evidence from the organisations in carer support in the social care context.

Liz Fenton: I am Liz Fenton from the Princess Royal Trust for Carers. We have an organisation which supports a network of carers centres throughout the UK: some 142 independent carers centres that provide a range of services for their clients—carers—within their area of benefit. They provide a range of services from emotional support to benefits advice, information on how to get respite care locally and training—a whole range of services. We support them by providing training, quality standards, policy and information, as well as ways of fundraising locally. We also have a national aspect, which is about translating national quality locally and vice versa, and bringing together nationally those local experiences of carers across the UK to inform policy at the national level.

Q452 Chair: Thank you. I would like to lead off, if I may, by picking up Emily’s point about the £119 billion of the value attributed to informal care. I want, in a friendly way I hope, to begin by challenging the thought process that lies behind that. We all know that many disabled elderly people rely on care from members of their group of friends and family, but for the great majority of people providing that type of care, the motivation to do it is not measured in money; it is measured in terms of the relationship with the individual. I wonder whether the case for proper support for carers, which is absolutely central to effective delivery of social care, is actually strengthened by trying to put a monetary value on what is for the great majority of people simply the discharge of their human obligation to a friend or member of their family.

Emily Holzhausen: I think that is a very helpful analysis. The value of that does a number of things. First, it shows the scale of support that we are talking about. Secondly, we know that people’s relationships are out of love and duty, and it is not on a monetary value, you are absolutely right, but it gives, I have to say, a great sense of value to carers themselves. They feel enormously emancipated by it, and for people who can often be very isolated and vulnerable, that makes a big difference.

The third thing is that there is a point at which a monetary value can be attributed to the support that carers provide, which is where it becomes important when looking at funding social care and that equation. If you were to look at carer breakdown or carer ill health, those equations really start to matter. So I think that part of it is absolutely true, and it serves different purposes, but we do not for a minute think that the 6.4 million carers across the UK are going to give up instantly, because they will not—and a lot of them tell us they will not—but many of them want more support, want to be understood and want a better social care system that functions better with health and helps rather than hinders them.

Liz Fenton: It is helpful to put a monetary value because, with the best will in the world, no matter how much a carer wants to carry on caring, if they are not adequately supported, they may not be able to carry on. There will be a cost to that, so it is very useful, as Emily said, to be able to put a figure to that, because then you can compare it with the cost of...
supporting a carer, which is minimal compared with the replacement care if they were not there.

**Q453 Chair:** There is a deeper philosophical question. I know Carers UK argues that we should be assessing care need for the cared-for person on a carer-blind basis. I wonder whether that is the right way to assess the care need of a particular individual or whether you should actually look at the pre-existing human relationships and say, “How do you support those pre-existing relationships, rather than trying to disentangle them?”

**Emily Holzhausen:** We argue it that way round—you have interviewed the commissioners, haven’t you?—because one of the difficulties that commissioners have is trying to get hold of how much unmet need we actually have in the system. That is part of the problem. If you do not know what unmet need there is, it is very hard to assess risk on that basis because you do not know the scale and the size of the problem. We say carer-blind assessment because we think that whoever ultimately takes responsibility for providing care—at the moment it is with local authorities—needs to know the level of need in that household, because then you can start looking at the levels of risk that you might have should things go wrong or people change their mind. What we know about families is that people’s first choice quite often is to look after family themselves. People like to sort problems out together or closely together, whereas we need a system that looks at people living at a distance. Which already happens in a much more informal way—is that people say, “Are you all right? Are you coping? All right then,” and do not really delve into it and get behind the great British mentality of coping and saying, “Yes, yes, I’m fine, thank you,” when that person might really be at breaking point but does not want to admit it or is worried about upsetting relationships. So if you know what the problem is, you are then able to look at negotiating the kind of support somebody is able to get.

People give very freely and willingly, but they do not want to give up their health. We have people who do not necessarily want to give up work completely. They might be willing to go down to part-time work, which is where flexible employment is incredibly important, but the other way round would probably undermine the caring relationship in the longer term.

**Q454 Chair:** There is a danger the other way, isn’t there? If somebody says, “Yes, I am fine, thank you,” they may actually be fine. The professional may think that in that set of circumstances they would not be fine but, given those human beings and the way they have led their lives, they are fine. The danger is that you seek to substitute your judgment for theirs.

**Emily Holzhausen:** Yes, but I still go back to the original thesis, that we should be looking at need as it is, and understanding that pattern. I think that will help us understand how families will change and their decisions around care may change over the years to come. We are expecting people to work longer and, particularly women, it is important to stay in the labour market for pensions and other reasons. It is important that we have a modern social care system that works with people and does not leave them in a double bind, making a terrible choice between looking after mum or your partner and having to give up work, which we find in one in six cases.

**Chair:** I have had my say. Valerie is first.

**Q455 Valerie Vaz:** There is a feeling that there is a standard family with mother, father and everybody else. Actually, 60% of carers are female and they may be—correct me if I am wrong—single parents or just a mother looking after a child, for instance. I was interested to draw out that: the majority of carers are female, and some are children, who really should be at school rather than caring. Is your analysis quite important in determining how much care is needed?

**Emily Holzhausen:** Absolutely. I think those family relationships are enormously important. We have different people with different needs. Families are completely different. You might be caring for a parent, a partner and a disabled child. That is all possible, and that is all within our membership.

We provide the secretariat for Employers for Carers, which has done an enormously important report recently looking at people caring at a distance. Those are people on the motorway every weekend up and down trying to sort out care for parents or perhaps older siblings who are disabled. I don’t think that those distance carers are necessarily recognised in the system. We have a system that looks at people living together or closely together, whereas we need a modern care system to ensure that those people are able to manage. That affects people in all walks of life who struggle with that, including here in the House. On the subject of children and young carers, perhaps Liz would like to say something.

**Liz Fenton:** Definitely. Young carers are recognised as a major area of caring in the family, where the caring role can become problematic. As has been said, it is part of normal family life for people to care for each other, but for young carers that can become problematic and they need the support to manage those care roles. Their needs need to be taken into consideration during the assessment as well. Often, with the separation of adult and children’s services, the contribution that children are making to care is overlooked and, therefore, their support needs are overlooked.

I very much agree with Emily that the support needs of the person with social care need to be assessed initially, but there is no reason why the carer cannot then be asked how much of that care they are prepared to provide. If it’s the other way round, there is an assumption that you will provide the care and we will make up the difference. If it is done from that point of view there is far too much temptation for local authorities to put pressure on carers to take up the biggest part of care and then make up the difference, which does not measure the actual care needs and risks and does not fairly make it clear what the care needs for that person are.

I should also point out that we have recently carried out some research into older carers, and the fact that the people with the highest levels of caring...
responsibilities are often over 65 themselves. So, when we are talking about the range of caring, we should remember that older carers are very much in the majority and have specific needs because of their own ill health. Sometimes people even take turns caring for each other through different bouts of ill health. But even permanent, full-time carers—we hear stories of people in their 60s with arthritis and so on having to lift an elderly spouse or an adult son or daughter with learning disabilities, for instance. We need to be aware that caring goes across the whole spectrum and there is not a particular pattern.

**Q456 Valerie Vaz:** I am sure we all recognise those cases in our constituencies. We all have cases like that. I just want to focus on the comment that you made about the tipping point. You mentioned it in your submission, but could you expand on it?

**Emily Holzhausen:** There is a piece of work that Linda Pickard did a few years ago, which was published in 2008. It looked at the probabilities of people providing care, and it explained that, given the trajectories of people working and ageing, and the amount of care that was being provided—the whole care system relies on a certain level of input from family, basically—there would be a point at which, given the current trajectories, the amount of family care available would no longer be enough. That was the tipping point that Linda described for 2017, which we talked about in our evidence. That publication was based, in 2008, on an increasing level of social care, and of course we have seen a squeeze to local authority budgets. I imagine that we are probably in that space now where we have reached the tipping point, and where there will be an increasing gap between what family can provide and what the state or private means provide. We are there now.

I advise carers day in, day out, and I get phone calls from people who say, “I just don’t know what to do. I don’t know how to get care, I don’t know how the system works and I am thinking of giving up work to care.” My concern is that it will start to eat into people’s choices where they give up work. What we see is that flexibility from employers, a little bit of care, better understanding and a better system can keep those people in work. We need that for the economy as well as for continuing later in life and pensions. As we all know, for people who fall out of work it is incredibly hard to get back in again.

**Liz Fenton:** There are much higher levels of poverty among carers for that very reason. They have to give up work and they lose out on their pensions. In addition, a recent survey found that up to 60% had spent all their savings on adding care to the package that was provided by the state. They are far more likely to be living in poverty, or certainly to be far less well off than non-carers.

**Q457 Andrew George:** This partly relates to the earlier debate about being care blind, or at least blind to the family support structure, and these two questions relate to each other, particularly in relation to poverty among carers. If you follow the logic of a care blind assessment and the increasing personalisation of care budgets, would you agree that perhaps the next step would be to allow carers to enjoy some of the budget that might be made available as part of the care plan, rather than to employ carers? Would there be a danger in doing that? One of the big problems, as just explained, is the poverty among carers and the fact they forgo a significant amount of income as a result of the time that they put into caring.

I just wondered whether that was an area of discussion that you as professionals have thought through.

**Emily Holzhausen:** Certainly carers have been talking about it for quite a long time, and it is a really complex area. It is possible to pay close relatives, which is essentially what you are talking about, through direct payments, and it has been particularly important where there has been no other service that has been right or available for somebody—for dementia perhaps, for somebody they trust within the family, for somebody from a particular ethnic background or for a complex disability. It has been very important. It has always pained me when we have had families on income support who have had a whole raft of workers coming in, and yet that family has been on the poverty line. That situation existed when we had the independent living fund, long before direct payments came in. It certainly would be a means to improve carers’ incomes by paying people where there is no other alternative, but it is not without its complexity in that your husband or your wife could become your employer. So it needs some examination. Certainly some people among our membership are very for it; others feel that they would never even wish to be paid for that care, it is absolutely the last thing they want. But we are not talking about one rule for everybody are we? We are talking about flexibility. So certainly that flexibility is critical because otherwise people would not get support. How far along the downward line it goes needs to be looked at and that is something which I imagine will be teased out as well with the proposals to bring forward a Bill and the Law Commission’s proposals.

**Q458 Andrew George:** Have you and the Princess Royal Trust for Carers thought of some of this through? Will you also be contributing to that part of the debate?

**Emily Holzhausen:** We have done quite extensively. We have advocated for being able to pay relatives—continuing the option of paying relatives—and you would need to be very clear about what relationship that carer then had within the assessment system. Just because you pay somebody, it does not necessarily mean that they can’t have an assessment of their own needs. It is complex. We could go into it, but you probably don’t want that at this time.

**Liz Fenton:** One final thing: I think it is really important that carers have the choice to retain that funding within the family rather than paying someone else, as long as it is a choice. My experience in local carers centres is that, where carers were being paid, they were also contributing huge amounts of unpaid care. So they were still unpaid carers, even though they were being paid for a few hours’ care a week.

**Q459 Barbara Keeley:** I wanted to ask a further question about the tipping point and the financial
squeeze that all families are under at the moment. During carers week I gave an example in a speech here of a carer locally who had had to take up an evening cleaning job. The only way she could manage her caring responsibilities and the evening cleaning job was to put her husband to bed at 4 o’clock, which goes against everything we believe should happen in terms of the human rights of people being cared for. Clearly, it is difficult sometimes for people to manage. How much closer do you think the tipping point may be in terms of both those difficulties and the impact of local authority cutbacks in care packages and of the financial squeeze? Presumably you are getting feedback about that into your networks with Carers UK and into your carers centres. Has the position changed a lot since all these factors have come into play?

**Liz Fenton:** We are seeing that there is a squeeze on the contracts for carers centres where they are being expected to provide more for less funding. That is one aspect of it. We are definitely seeing a squeeze there. Also there is a reduction in social care expenditure generally and that has an impact on carers because, where are the money is not being provided, carers are making up the difference on the whole. Carers centres generally are reporting far more cases of people in financial difficulty—debts in particular. Having spent all their savings on additional care they are now really up against it. Some are borrowing at massive interest rates in order to keep going. That seems to be an area of work that has expanded beyond recognition in carers centres over the past few years.

**Emily Holzhausen:** We run the secretariat for the Care and Support Alliance which is about 55 organisations. Last year we found that services were being cut—this is from memory and I will have to go back and check the figures; I can always provide a note to the Committee—by about 12.5%. That was before the budget squeeze really took hold. We have seen increased charges. Around 9% of people have seen an increase in charges, and the FOI requests that appeared in the press over Christmas suggested that charges have gone up by 12.5%. So it is not just a cut to a service, necessarily; it is also the increased charges that are placing a squeeze. What we have found, fortunately enough, since charges were introduced is that about one in seven people start to refuse services because of worry about paying charges. We are finding that a lot more people are being reassessed, or they are being told that their charges will go up, so we have asked carers to contribute their examples. We will see, for example, somebody who has a bill of almost nothing go up to £250 a month, and they are coming to us in desperation saying, “How on earth am I going to pay this?” Some of those processes that the local authorities have in place are not really working properly, in terms of making sure that people are properly financially assessed.

**Liz Fenton:** And the choice and control as well. Sometimes the replacement of the care—for instance, day care—may be reassessed as a payment that is often much lower than the actual cost of providing day care. Therefore, the replacement they are able to put in place is nowhere near what they were getting before. It is not universal, but we hear about these things.

**Q460 David Tredinnick:** How can carers—I want to change direction slightly—help prevent the breakdown of support for a cared person and stop or reduce the likelihood of them requiring more intensive care?

**Emily Holzhausen:** On something that Liz said earlier, it is really important that people are given the right information and advice about someone’s condition. We expect nurses and medical professionals to be trained for years and years, but we expect a family member to go away with a diagnosis of just, “Well, sort that out. You are on medication, there you go.” Five different lots of meds to take a day—have you any idea what they do, what their side effects are, how they work in combination, or how you are supposed to make sure that somebody can eat properly and will sustain a healthy life? The programmes that we have run around training are incredibly important, and it is about looking after carers themselves. A lot of carers centres run training, don’t they?

**Liz Fenton:** Centres do. We have taken part in a Department of Health programme looking at how carers can be supported within the NHS to help prevent carer breakdown. There is not enough evidence at the moment, but there is evidence that failing to support the carer means that people are readmitted to hospital with secondary problems and infections and that carer breakdown is the cause of admission into either hospital or long-term care. It is important for the carer to have the information and tools to be able to provide the right level of care to the person they care for, and to care for their own needs. We know that incidence of ill health, and particularly mental ill health is much higher in carers than the rest of the population, so it is about them being able to support the person they care for, to prevent their condition worsening, but also, even if that happens, for them to be able to continue caring. The research that we did last year showed that, on average, by supporting the carer, the carer can continue to care for approximately two years longer.

**Q461 David Tredinnick:** How does that training and advice vary across the country? Is it uniformly good or uniformly indifferent?

**Liz Fenton:** The difficulty is that what we have been trying to do is persuade the NHS to provide their care; for instance, if somebody has a stroke and is then discharged to go home with the family, to make sure that the family are properly supported and trained at that stage. There are all sorts of other interventions within the NHS. It is very important there, and that GPs recognise carers as well, so they are able to make sure that they are properly informed about medications and so on.

**Q462 David Tredinnick:** Yes, but in answer to my question, are there any black spots in the country? Are you aware of any areas that are a particular problem?

**Liz Fenton:** I think they are everywhere.

**Q463 Chair:** Are there any white spots?
Liz Fenton: Exactly. It is better and easier at the moment to pick out areas that are doing very well. They are around the demonstrator sites and the particular carers centres that have been funded to specifically provide that kind of support for people. For instance, in East Sussex, for a long time we had a back care advice service. A lot of areas have that, but it is very patchy. It is one-off and depends on how well the carers centre has been able to make the case locally and how much funding is available. To some extent that was very successful, because that project showed the importance of supporting carers to maintain the health of their back and it has been mainstreamed.

Q464 David Tredinnick: Fair enough. However, our briefing says that 62% of carers rate their quality of life as good. Does that mean that the burden on carers is not actually too high at all?
Emily Holzhausen: It tells you that 40% do not. That is four out of 10.

Q465 David Tredinnick: Well, it is a very large majority. It is well over half who are satisfied, so what are your comments on that figure?
Emily Holzhausen: I think that they are very positive. It says a lot of good about our society and how people feel about caring, which is something that we should celebrate. What Barbara and Valerie also talked about was that we have a spectrum of care. We have people who are caring at the heavy end, some of whom will fall into that 62% and who will be very happy with how things are. At the other end of the spectrum we have people who are extremely hard-pressed. Four out of 10 people saying that they do not have a good quality of life is still a significant enough proportion for me to be concerned.
Liz Fenton: That 62% as well can very quickly drop off if they are not properly supported. If there is a sudden change in the condition of the person they care for, for instance, if they are not monitored and supported, they can suddenly go into that other 40%.

Q466 David Tredinnick: Is there an effective mechanism in place to give us the information about the benefits to carers of the caring role, as well as the burdens it imposes on them? Are you happy with the structure?
Emily Holzhausen: Yes. We have done the research on it. If you ask people, there is a lot on our online carers forum, which is run by carers, on the affirming stuff of caring and how people feel that they were able to give mum a good end of life and a good death. They were able to keep their sons and daughters living in the community and playing a full part in the community and were able to give their children the longest and best quality of life possible. There are some very affirming things there. We try to bring that out during things such as carers week, but there is also concern on those four out of 10 when things start to bite.

Q467 Grahame M. Morris: I want to take you back to an answer you gave the Committee a few moments ago. I think we all accept—certainly I do—that carers exemplify the good society and make a huge contribution. This informal, unpaid care is often to family members. There has been an attempt made by the Department of Health to quantify that. Can you quantify the numbers involved for the record of the Committee? I know that you have done that in the written evidence.
May I also take you back to the answer you gave a little while ago on the increased charges and the pressures on social care, not just in terms of care charges, but in terms of transport charges and so on? How does that square with the number of assessments that are being carried out on carers and, subsequently, those carers being awarded care packages? Is that at odds with the fact that we have this huge number, with growing demands and growing pressures on them, yet the assessments and care packages for carers are failing?
Emily Holzhausen: Yes, that is a correct analysis. You will have seen from other evidence that the amount of care hours that are provided in a community are going up, but to fewer people. Who else is providing care to those very vulnerable people? Are they self-funding or is it family? What we are seeing in the statistics of carers is that you have a steady increase at the heavy end of over 50 hours of care from about 650,000 to 750,000 in 1985 to more than 1.25 million now. We have seen that increase again on population projections. Family is increasingly taking on that role. To go back to the number of assessments, it is difficult to say, because the performance criteria drove assessments. So it’s hard to say whether people are actually getting better outputs or not. The number of assessments for carers did increase, but I am not sure where they are now, to be honest, with data. Certainly, the charge is increasing—as I say, I think it’s about 12.5%. It is having a squeeze on family incomes. People do have to make a hard choice about what they are going to spend on. Is it going to be family? Is it going to be food? Is it going to be the children, or am I going to say no to that service?

Q468 Grahame M. Morris: I understand. I don’t know whether you can confirm this, but figures that have been provided to the Committee indicate that there has been a 3% fall in the number of carers assessed and a 2% fall in the numbers receiving a care package arising from that assessment in 2010–11. Is the total number of carers, in your estimate, around 5 million adult carers?
Emily Holzhausen: It’s 6.4 million across the UK. I can’t remember what the numbers are for England. It’s about 5.4 million, roughly, for England and Wales.
Liz Fenton: The household survey 2009–10 found that only 4% of carers are being assessed. Nearly half had had only two days’ break since they started becoming a carer. Even for those who have had an assessment, approximately half of the cases we looked at had had only simple information, and not even a referral to their local carers centres.

Q469 Rosie Cooper: You’ve talked very generally about the issues today, and I’d like to drill down to a couple of specifics. Before we do, do we have any
Emily Holzhausen: An enormous, well—

Liz Fenton: It depends how you define that. People who care for only a few hours a week, who might actually be making all the difference, may not identify themselves as carers. The biggest problem that we have in our sector is that people see themselves as doing something that is a normal part of family life, and not as carers. They may be the 62% who are carrying on quite happily. It becomes about making sure that people recognise, when they need support, that they are carers and that they can get the support that they are entitled to from being a carer. That is a major problem: to get people to identify themselves, let alone other professionals to help identify them. Sorry. What was the question again?

Q470 Rosie Cooper: Basically, have we got any projection of how big the number might be out there?

Liz Fenton: The last census had 10% of the population. It corroborated the view that we had before, which was that it was about 10% of the population who recognise themselves as providing a caring role.

Q471 Rosie Cooper: I ask the question because we visited Lancashire. In my area, there is a huge increase in cost and the take-up is dropping dramatically. But I also speak from a personal level. For example, both my parents were profoundly deaf, having been born deaf. As a child—I was the eldest child—I would be and have been the carer there the whole time. But I would have never recognised that, because that was normal; that is what we did and we got on with it. Now, my father is 87. He has had a number of strokes and needs a lot of support. What is absolutely amazing to me is, for example, he has vascular dementia, and the psychogeriatrician says that he needs to go to a day care centre. That is not a question of money. The day care centre says to me, “No point in him coming here.” Why not? “Can’t communicate with anybody. Therefore it is pointless.” He is not going to go into a home. I preface that before I say the next thing—I am not exactly unable to make that noise, and it is not met. Has to be on the table. I am not exactly unable to make the answer, but there are always difficulties, definitely. Where there is an answer, we help the carer to find a way to get somebody to find the support and you do all those things. You actually do not know when this will come out. It is not just the fact that your father is deaf; it is also the fact that he has dementia. Somebody has to understand the communication issues that you have with both, because they are quite significant, and that is why we need to measure it.

Q472 Rosie Cooper: It’s okay us talking about the generality, but how does the specialism—the communication difficulties—figure?

Liz Fenton: That is why the personalisation agenda is so important, so that people’s needs can be looked at individually and they can buy in the support that they need rather than having to go to—

Q473 Rosie Cooper: How can you go to a day care centre that is not there? How can you buy a residential place that is not there?

Liz Fenton: In circumstances like that, the family needs to be talked through the options to get the outcome that they need, but it may not be from a day centre. It may be from someone visiting. There might be all sorts of other ways that that need—that outcome—can be met without necessarily one particular answer.

Emily Holzhausen: He should be assessed as part of the care package.

Q474 Rosie Cooper: He has been.

Emily Holzhausen: Exactly.

Q475 Rosie Cooper: And there isn’t an alternative. I have explored every avenue, from the leader of the council right through to every system going—health and social care—and the answer is that there is no provision. So where is it?

Chair: You are a carer elected to the House of Commons.

Rosie Cooper: That’s my frustration. There will be a lot of people out there who are stuck in a conundrum of this sort—it will be a different conundrum—and it has to be on the table. I am not exactly unable to make that case and make that noise, and it is not met.

Liz Fenton: Definitely. We see that all the time. There are all sorts of examples of people who are in dire straits in sometimes unbelievable situations of caring, and there appears to be nowhere to pick them up. At least with the carers centres and the local information, we are able to provide support and information. Where there is an answer, we help the carer to find the answer, but there are always difficulties, definitely.

Emily Holzhausen: Also, it is partially a lack of understanding of the real importance of communication needs and cultural need among different communities—for example, the blind and deaf-blind. But it is also an issue of squeeze on funds. We are seeing increasing numbers of specialist services that are less available.

Q476 Rosie Cooper: Absolutely, and interpreting is a big one.

Emily Holzhausen: It’s a huge one.
Q477 Dr Wollaston: Can I move on to the Dilnot commission? You have both set out very clearly some of the financial burdens on carers—the shocking data that 60% of them are using up all their savings and a further 53% are borrowing money, often at high interest rates, to cover their costs. You have also stated—I know Liz Fenton has—that the priority has to be on reducing the financial burden on carers. How far and to what extent do you think the Dilnot report addresses this, and how successful do you think it would be if it was implemented?

Liz Fenton: I think it would be a definite step in the right direction. It would mean that there was a clearer sense of eligibility across the whole country, so that would be helpful for carers. They would know exactly what they are dealing with with their local authority. It would not be left up to local decision making. The cap would be very helpful as well. Certainly where carers may be relying on whatever is left of the estate to be able to live on after the person they care for passes on, for instance, that could make a huge difference. I don’t know whether Emily wants to add anything.

Emily Holzhausen: I agree with the cap on the spending of savings on care. One of the other important things I wanted to say—because we are very interested in systemic change and long-term change—is that the fact that people come only to our services when there is a crisis. People do not plan for care. They do not expect it, yet the statistics of people who require care—from a cleaning service because they are getting increasingly frail or less able to manage all the way through to very complex care—show that it becomes something that virtually all of us expect to need at some point in our lives, yet none of us is planning for it. That is one of the difficulties. You do not necessarily expect your husband to be diagnosed with MS; nobody wishes that one of their parents would get dementia and what might happen in their lives or, indeed, other conditions. Too add to what Liz said, the forward planning and the understanding that something like that might happen to us is incredibly critical. It might be that the carers’ financial situation has improved because the person who they are caring for has planned well for care, and has the means to buy care or go through the system and be properly supported so that the carer does not have to supplement anything.

Q478 Dr Wollaston: Do you have a view about the level of the threshold and the level of the care?

Emily Holzhausen: The cap is where it is set. I know you want to share with the Committee in relation to the Law Commission, do you have any particular thoughts that you want to share with the Committee in relation to how that will impact on carers?

Liz Fenton: The recommendations about the assessment are very, very important. We are provided by family carers. Do you agree with that or do you think that it is something that perhaps the Dilnot recommendations did not get right in its record or should change?

Emily Holzhausen: We did look at it. It is quite a complex issue looking at metering. We thought that the Dilnot proposals were quite clear—clearer than what we have now in terms of the system, and that has to be a good thing. What is complex in metering as well is that it might not just be the older person who is spending their own savings; it might be the carer who spends their own money to support them, which a number of people do. Our basic tenet is that carers are not made worse off and that they have to be supported by the system.

With the Dilnot report, you have to spend up to £35,000 anyway for savings in order to have your assets protected. In some respects, the difference between spousal and son or daughter is complex. If it was spousal care, it is usually shared assets, whereas son or daughter care is a different relationship. There are a few complexities in metering that we need to tease out.

Q480 Barbara Keeley: But are you concerned that there is a disincentive for families to provide care, given that it does not count towards the £35,000 cap? If outside care were brought in, that clocks up towards the £35,000 and then care can become available. But all the equivalence of providing informal care doesn’t count.

Emily Holzhausen: No; I am not worried about a disincentive to provide care because it might affect a few cases but, on the whole, we do not see people making decisions to provide care around that. They tend to spend money where they really need to, unless they really feel that they cannot afford it. They tend to make choices around care based on love duty and those kinds of relationships. I would like to examine it perhaps where some of the relationships are more complex, but I am not worried about it being a disincentive.

Liz Fenton: However, if it is a positive choice, that is good thing generally, anyway. If that allows a positive choice to care, rather than a requirement to care, that has got to be better for the carer and for the person that they care for, so that they are not under stress and they do not feel that they are doing something which can be a very tense situation, particularly if they are caring for someone with challenging behaviour in some way. To have positively made that choice out of a decision that we want to give the best care, increase independence and all the good things that can come from caring, that is much better than having to make a decision because of money.

Chair: Grahame, do you want to raise the impact of the Law Commission?

Q481 Grahame M. Morris: In relation to the framework that has been proposed by the Law Commission, do you have any particular thoughts that you want to share with the Committee in relation to how that will impact on carers?

Liz Fenton: The recommendations about the assessment are very, very important. We are
concerned—this is very important—that the assessment is not seen as an end in itself; it is obviously a means to an end. We would not want assessments to be seen as the achievement; it is really what comes out of that. At the same time, having said that, an assessment can often be the first and only time that the carer has had a chance to talk about their life and the stresses and strains that they are under, and so on. If it is done properly, an assessment can be a very empowering and very important part of the caring process. We would very much support assessments, and for those to be done at the same time as the social care assessments, so long as they are separate and independent.

Q482 Grahame M. Morris: In relation to the carers’ assessment, you would strongly support the particular recommendation on the issue of portability—to end the postcode lottery and inconsistencies?

Liz Fenton: Definitely, even if it is only for the time that it takes to reassess in the new county or whatever, because that gap can be huge. I would also argue that there would have to be a strong case made for any major changes. If there is an eligibility criterion that goes across the country, quite a case would have to be made, I would argue, to change that assessment massively.

Q483 Grahame M. Morris: Is there an argument for ring-fencing money specifically to support carers, perhaps for respite care? There is a huge issue about unpaid care and so on, but in terms of supporting them in their activities—supporting relatives, families or friends—is there an argument for trying to ring-fence an element of money just for carers for that particular purpose, rather than it going to the individual who needs care?

Liz Fenton: Yes, I think there is an argument for both. It is whether it is a need for the person who is cared for or for the carer, but definitely, if there is a carer involved in any form with either assessment, there needs to be a strong consideration of their needs for a break. The present Government have made money available through the primary care trusts for respite. Unfortunately, very little of that has actually been used for respite, but we saw that as a real step in the right direction. It is very important that carers are able to get a break, and that the person who they care for gets a break from them as well.

Q484 Grahame M. Morris: I think the last Government made money available for respite.

Liz Fenton: That’s true.

Q485 Grahame M. Morris: My particular PCT ring-fenced that and dedicated it for carers.

Liz Fenton: But very few did, unfortunately. Although we are hoping that that will change over the coming year, we have not seen a lot of change; there has been some change.

Emily Holzhausen: May I add something to the legislation point? I think it is an enormous opportunity for us all to simplify things and, to come back to your point about care-blind assessments, to have the proportionate assessment so we have light touch, which is incredibly important right to the other end of the spectrum. The other two points I wanted to make are—

Q486 Chair: Before you move on, what did you mean by light touch? Who is in favour of heavy touch?

Emily Holzhausen: No, well, you do need complex assessments where you have much more risky situations, very complex family relationships and complex disabilities—that kind of thing—so you would need more time, more professionals to come in and have a look. But where we can, we should be looking at lighter-touch assessments and using the expertise of families as well.

There are two points I wanted to make about the legislation. One is that, when we go forward, we will end up with some rump legislation, as it is called; it is not a very nice term. We are talking about giving stronger rights to carers caring for adults. We need to remember that parents of disabled children, for example, will not necessarily have as strong rights as adults caring for adults. We need to remember that we need to link the legislation up with young carers. We need to ensure with any legislation going forward that they link up and we accord the proper rights.

The final area is around integration. I don’t think it was possible for the Health and Social Care Bill, but we need to look at the shape of social care legislation and whether we should look at additional integrated duties on health to look after carers. I won’t get into the Health and Social Care Bill now.

Chair: Indeed, that is quite a big subject. Andrew.

Q487 Andrew George: Going back to the portability of care. To what extent do you both take the view that what we should be driving towards is a national standard, and that there should be less—or indeed no—local variability to that? As a supplementary, I would like to ask to what extent the problem of variable assessments and lack of portability of care is a problem. Isn’t it the case that most care settings mean that a lot of people are not terribly mobile and, therefore, we are talking about only a small proportion of families where that might be the case?

Emily Holzhausen: There are two issues there. One is the portability and there are a small number of families who move or wish to move, and that causes a number of problems, as you know. Possibly people make decisions not to move as a result of not being able to guarantee what will come, and the uncertainty of that.

The other issue is that portability has around national entitlement eligibility criteria. There is the evidence you will have heard from other people around being able to plan for the future if you know what you are going to get. That universality is a basis on which we can all plan, not just the insurance industry or any other mechanisms. It gives us a common centre and hopefully makes things easier for advice services like ours at a national level, or indeed at a local level, to explain the system, which takes hours and hours of our time. We are an over-subscribed service; we have a very high percentage of people who cannot get through.
Liz Fenton: The thing is not just the eligibility as far as things go wrong; they go spectacularly wrong. Possibly get a different view from a different set of ones that go right. If I am taking advice from the ones that go wrong, so we won’t get to on the whole. The difficulty is that we will tend to that it is an extremely long, drawn-out, painful process. We have found that a number of cases have ended up in the High Court. We have found that it is an extremely long, drawn-out, painful process on the whole. The difficulty is that we will tend to hear of the ones that go wrong, so we won’t get to hear of the ones that go right. If I am taking advice from my information advice service rather than surveying the population as a whole, you would possibly get a different view from a different set of cases. Where there is complex care involved, when things go wrong they go spectacularly wrong.

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Liz Fenton: The thing is not just the eligibility as far as parity. It is the portability in the sense that if you have got a complex package of care for someone you care for, say a child, and you have all sorts of different components of that care, it is getting that put in place in the new place. It is not just whether you are eligible for it; it is getting it so that it is in place. You cannot wait a month for the care that that person needs to carry on being at home. They may need constant 24-hour care at home. They cannot say that they will wait a month until they are reassessed and then decide what package of care is. It doesn’t work like that.

Emily Holzhausen: That is a very interesting question, particularly given the developments with the new personal independence payment and the way that is being assessed. I do not think the national assessment is moving to be as prescriptive as the personal independence payment. I think that decisions and spending on care will always be local issues in terms of what you can then buy, how it configures and what other support and family networks you have locally. How that happens is very different.

Chair: Can I push you a little on this? It seems to me that we are in danger in this world of accepting some of these concepts as no more than common sense, without thinking about what the implications are. With the concepts of portability, national assessment, personal budgets and cash payments—and I set them out in that order—it seems to me that what you are doing, if you are not careful, is reinventing social security. I wonder how that is remotely compatible with light-touch assessment of different circumstances in families and with genuinely personalised social care. Is there not a choice to be made between whether we go in the direction of a very standardised system, which will be one size fits all because it has to be at a national level, or a genuinely personalised system that is capable of being flexible at a local level? Is there not a choice to be made?

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be a huge step in the right direction if the NHS had a statutory responsibility for supporting carers.

We have found that carers are in crisis when the person they care for has to go to hospital, and yet they are often not recognised at that time. We have found that we can make a huge difference by being available in hospitals and around the discharge process, and being there when people come out of hospital. It is the time when they are amenable; they recognise themselves at that stage, because it is a crisis. There are other touch points where we can get in touch with carers.

As we have all said, it is very difficult because there is a point at which you change from it being a normal part of everyday family life to being a carer. That may creep up on you over years, or it could happen suddenly with the birth of a child or someone having a stroke. There are all sorts of ways it can happen, and because of the nature of the role and the isolation of carers, and the fact that they are not necessarily identified by the professionals or the community around them, they can spend many years struggling with massive responsibilities and stress without any support at all. We have got to find ways of reaching them at an earlier point when they are relatively happy and saying, “No, I am fine with the caring role”, and making it clear that when and if it does happen — and also to reach them at a stage before they go into crisis, so that we can hopefully prevent that crisis.

Emily Holzhausen: One of the issues, and Andrew Dilnot has said this on several occasions, is that care tends to be a private matter that people do not necessarily raise. They do not necessarily raise their need for care. We have some fantastically vocal disabled people in our communities who do, but it tends to be a private matter that people do not raise. We have to really change that and put it much more into the public domain. There will be a lobby of Parliament on 6 March—I hope I have got that date right—where disabled people, older people and carers will be coming hopefully to meet MPs, to say how social care needs to be reformed and to emphasise the urgency of that. It is incumbent on everybody, and one of Andrew Dilnot’s recommendations was to make it a public awareness campaign. In this short period that we have before we have a White Paper, I hope that we can make a huge difference by being available around hospital discharge, and in particular around hospital discharge, for example, which is a classic point where you expect the family to pick up, 30% are not consulted about it and it is too short and about 28% thought that emergency readmissions were a result of too quick discharge and not proper assessment. That is where if you are interacting with the NHS it becomes problematic. Across the whole NHS if we have things like the QIPP programme, where we embed carers in that, making it part of productivity and performance, we completely change the relationship that the NHS has with families.

Q493 Dr Poulter: I don’t think that is true of healthcare professionals when looking at the families. I think perhaps the funding structure of the NHS does not recognise necessarily the role of carers and their support. Is that a fair point because it would be very disingenuous to professionals to say that?

Emily Holzhausen: No. I think it is disingenuous to say that the whole of the medical profession does not do that. That is completely disingenuous. I apologise.

Q494 Dr Poulter: It is certainly not what I saw in the summer when I was working with doctors.

Emily Holzhausen: There are some fantastic medical professionals out there. When we look at the data around hospital discharge, for example, which is a classic point where you expect the family to pick up, 30% are not consulted about it and it is too short and about 28% thought that emergency readmissions were a result of too quick discharge and not proper assessment. That is really where we want to change things. You need to see people as partners. The best medical professionals already do that and where that happens—

Q495 Dr Poulter: Do you think it is that the system is set up in a way that does not allow professionals to do that effectively much more than that professionals do not want to do it?

Emily Holzhausen: Yes.

Q496 Dr Poulter: The way that the tariff system is set up in hospitals, for example, and a payment by results system encourages short-term views and institutions to do what that institution does rather than to look at the whole person or the family and the issues to do with discharge planning in an effective way. There are good examples where it happens, but
the system is set up in a way that does not support professionals in doing those things.

**Liz Fenton:** No matter how good, they are they are not measured for being good at supporting carers. They are not funded for it either, so that is a major disincentive. With discharges, for instance, the incentive is to get someone out of hospital as quickly as possible, not to make sure that they don’t come back in a month’s time because that is a different funding stream. That sort of thing has not been thought through. The short-termism is a major problem, particularly with hospital care. They are not looking at what might happen if the carer is not supported, in that they might not be able to maintain the level of care that is needed without training and support.

There are definitely disincentives. There are few incentives and lots of disincentives for supporting carers within health. There is no real measurement yet of the benefits to the NHS of supporting carers. Benefits are usually shown as social care benefits. There is no immediate and short-term benefit to the primary care trust budget, for instance, of supporting the carer, even if it is about the health of the cared-for person; that tends to be long-term and has not been quantified.

**Q497 Dr Poulter:** So in summary, you are saying that there is a financial fragmentation of care and people then have to present in crisis, as you were saying earlier, with that revolving-door syndrome where people don’t get the proper discharge planning that they need.

**Liz Fenton:** Exactly. By that time the care has probably broken down and they will have to go into care or not come out of hospital for a long time. That is not necessarily the problem of the hospital. A lot are taking that into consideration. We know a number of PCTs that have invested in support for carers, but it is quite minimal compared to the need. It has shown huge benefits to the hospital environment, apart from anything else, and the strain and stress on nursing staff, to have carers properly supported. Often that relationship breaks down and then causes problems for the nursing staff.

**Chair:** It is a subject to which we shall return. I am sure, many times and probably in the next session as well. Thank you very much for your evidence. You have given us plenty of food for thought.

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**Examination of Witnesses**

**Witnesses:** Dr James Mumford, Senior Researcher, Centre for Social Justice, and David Orr, Chief Executive, National Housing Federation, gave evidence.

**Q498 Chair:** Thank you for joining us this morning. I would like, if I may, to ask you to begin by introducing yourselves and your organisations, and to say a very brief word about the interest that your respective organisations have in the inquiry we have going on into social care.

**David Orr:** Thank you very much. I am David Orr, chief executive of the National Housing Federation, the trade body for all the housing associations in England. Our members house about 5 million people. Over half the housing associations in the country provide specialist housing and support of some form or another. You will all be aware of the large-scale specialists, like Anchor and Housing 21, which provide for older people a huge range of other support and care services, covering a whole range of different people. However, this is not just an issue for us of the specialisms within housing associations or specialist organisations. Something like half of all housing association tenancies are now held by people who are 60 or over. It is our assumption that that group of people, as they age and become more frail, are likely to require considerable degrees of support and care, and that very often that support and care will be provided in their home rather than in some external residential setting. Indeed, we think that is exactly as it should be, but we do not think the systems and structures are in place yet to ensure that it is properly delivered.

On a broader point of introduction, those of us who have been involved in housing have felt a degree of frustration over the years that the health and social care debate is a health and social care debate. We think it needs to be a housing, health and social care debate, because it is almost impossible, outside the delivery of acute services, to consider how best to meet someone’s needs unless they are properly housed.

**Chair:** Thank you.

**Dr Mumford:** My name is James Mumford. I am a policy researcher at the Centre for Social Justice, which is an independent think-tank established by the right hon. Iain Duncan Smith in 2004. We had done a lot of work as an organisation on the causes of poverty in the UK, around the “Breakthrough Britain” report in 2007, and we arrived at 2010 realising that older people and poverty—which many older people face—was an aspect of social breakdown in the UK that we had not focused on. We were commissioned to do a review for 18 months, and we wanted to look at a number of issues in the round to do with older people, so that we did not miss out things like housing, but social care was an important part of what was the final report published in June 2011, “Age of Opportunity”. I had the opportunity, over 18 months, to travel the country and to visit lunch clubs, day centres, befriending charities, extra care housing and dozens of care homes, hospitals and home improvement agencies, and to talk to hundreds of older people. It is from that experience that I would like to draw this morning.
Q499 Chair: Thank you. I want to begin, if I may, with a set of questions related particularly to the housing agenda and the theme that Dan Poulter was concluding on with the last set of witnesses: the importance of integrating health, social care and, according to the point you just made, social housing. How do you feel that agenda is going? What are the principal obstacles to delivering more integrated services and what are the opportunities available to us if we deliver those services more effectively than we have in the past?

David Orr: First, I don’t think it is just about social housing. Clearly, housing associations are what we do, but I think that this is a broader housing question about proper integration. What are the advantages? Let us start with the most obvious kind of example. If someone is getting a bit frail and a bit unsteady on their feet and it is possible to install some grab rails in their home, it may reduce or even eliminate the potential that that person will fall, break their hip and need an acute emergency admission. That is good for absolutely everyone, but there is not a strategic environment where the discussion about how those relationships fit together takes place. The proposals in the present Bill on the creation of Health and Wellbeing Boards could easily be precisely that place, if it becomes an environment for people who have a degree of expertise and a legitimate interest in that strategic overview. It is not just about operational stuff; it is about thinking strategically about how we create the environment in which it is possible for different voices and different expertise to be heard. It would be true to say that our experience of the health service is that it is quite a self-contained organisation. In a way, it is so big that it is difficult to find the routes to that kind of strategic discussion, either at a national level or a local level. Health and Wellbeing Boards may well be a mechanism for doing that.

You will not be surprised to learn that we think that there should be, as a matter of course, a housing voice. It does not really matter specifically whether it is the local director of housing or someone from a housing association. What matters is that that degree of expertise is available at a local level to inform the thinking that goes on. I think that the advantages of doing that are potentially quite profound. We gave a very small example in our written evidence of Havebury Housing Partnership, which has come to an arrangement with a local hospital about discharge. They provide a flat, at a cost of £150 a week, which stops someone potentially having to stay in hospital while the discharge programme is properly set in place, at a cost of £2,800 a week.

There are examples all over the country. The Home Group is presently exploring “the good death”. I think it is using that terminology and I hope it continues to do so. It is well aware of the fact that the huge majority of people say that they want to be able to die in their own home. Well, Home Group, like every housing association, is providing many of those homes. It wants to explore how it is possible to help to make that happen much more cost-effectively for society and much more comfortably for the individual. It is about exploring individual components of this, as well as putting in place a strategic environment where it is possible to bring the issues together and think comprehensively about how the different components relate to each other.

Q500 Chair: Is there any academic or research evidence that you would point the Committee towards that looks at what opportunities exist to improve the use of the resource and the efficiency and quality around the kind of integration that you are talking about?

David Orr: The research evidence in this territory is flimsy. The kind of research evidence that we have is about impacts. There is research evidence of the value of having a warm and secure home, in terms of reducing demand on the health service. There is research evidence about the impact of the supporting savings, for example: £1.6 billion generating £3.4 billion of savings, and many of those savings are in health. However, more open-ended pure research of the kind that you are suggesting, Stephen, is thin on the ground.

Q501 Chair: I asked the question partly because I wondered whether Dr Mumford in his travels round the country had identified this as an opportunity for improving the structure of the way care services are delivered.

Dr Mumford: I would agree with Mr Orr about the research base academically around this. We have seen from the most dynamic home improvement agencies working in the private sector—I know less about housing associations—key interventions, which have literally saved people from hospital admissions. I can think of one in Leeds I went to where things as small as grab rails, ramps and stairlifts—that kind of intervention housing-wise—have had a huge impact on health, although the savings for the health service do not incentivise. They are for the health service, even though the investment needs to go in through the disabled facilities grant system, or through local councils. There is definitely an evidence base around that.

Q502 Rosie Cooper: I was going to ask a question about standards, but I would like to react to some of the things that you both just said. For example, regarding Health and Wellbeing Boards, I hear you talk about the strategic aspect, and how they might influence or inform thinking. I am totally supportive of Health and Wellbeing Boards but the truth is currently, in my view, that they are powerless. They can think and talk and strategise but they cannot actually drive change. I wonder whether you could say how you thought that Health and Wellbeing Boards would be able to drive change and link commissioning for health and social care together, and how they would acquire the teeth to enforce and not just advise. We are awash with advice; we actually need to make some changes.

David Orr: That is a very good question. The relationship between enforcement and getting on and doing things is a critical question. I am not absolutely certain that enforcement is necessarily the best way to achieve the outcomes that we are looking for. I think
the closest parallel that housing associations have been involved in have been local strategic partnerships, where you might say that many of the things about those strategic partnerships are similar to the proposals for Health and Wellbeing Boards. The experience of local strategic partnerships might be described as under a normal distribution curve. At one end some of them have been stunningly good; at the other end some have been stunningly bad. In the middle there is a range that varies. What characterises the good and the bad? Can we learn from that? Can we make sure that these things don’t happen? If I can start at the negative end, the thing that characterises the bad is where people attend them believing that their job is to stay in control and to say, “We are the local authority, we own this, we are not really going to let anyone else influence what we do.” At the good end, it is regarded as an open opportunity for people with knowledge and expertise to contribute to how we improve this society, this place; how we improve the decision-making process. You may have a Health and Wellbeing Board with enforcement powers, but if it is operating at the bad end, the enforcement will not be helpful at all. How do we construct these, so that they have the people on them and the willingness among those people to make them fly?

Q503 Rosie Cooper: Absolutely. Let’s just talk about the good end. We have an absolutely fabulous Health and Wellbeing Board and we have come out with a really great strategy that does not actually tie in with what the commissioning board wants to do. They don’t have to be listened to; they just have to be present. What happens then?

David Orr: One of the major questions in all of this is about the quality of commissioning. If you have a great Health and Wellbeing Board and poor commissioning, and if you give the Health and Wellbeing Board enforcement powers to tell commissioners how to commission, is that going to provide a sensible solution? I don’t know. It is not something that we have given much thought to, because it seems an improbable place to get to, but it might.

Q504 Rosie Cooper: I will leave that one there. I would just leave you with a non-enforcement type of statement: I know of one local authority where a non-urgent appointment with an occupational therapist would take 87 weeks.

David Orr: We know plenty like that.

Q505 Rosie Cooper: So we need a lot more. The Committee has heard that social care standards in England are very low and that residential care accommodation standard is probably the worst in Europe. When we met the CQC, it indicated that it monitors at minimum levels. Do you agree with those statements? Do you have any evidence to support that?

David Orr: I have no basis in proper research evidence that we have gathered to challenge that statement. We have not done a kind of specific exercise that looks solely at the experience of housing association-provided care. My anecdotal evidence from spending a lot of my life touring the country, meeting housing associations and seeing the work that they do is that the majority of it is of quite good quality. I have visited establishments where I think, from my non-expert view, that the amount of thinking that has gone into how you provide good residential accommodation for people with dementia is at the cutting edge; it is as good as you can find anywhere in the country. But we have not done a kind of specific piece of research about the experience of housing associations and the care provision.

What we do know, of course, is that housing associations involved in this are regulated not just by the Care Quality Commission, but by what is presently the Tenant Service Authority—that’s about to change. I tell you what. If you are working in a housing association, it feels like the regulation is pretty stringent.

Rosie Cooper: Oh well, let me tell you: I have had a great deal to do with the TSA recently, and I can tell you that other than the nuclear option, they might make you feel a bit frightened, but they do not actually deliver.

Chair: That is slightly outside the scope of our Committee, if I may say so.

Q506 Rosie Cooper: Dr Mumford, do you have any comments about the standard of provision?

Dr Mumford: Yes, absolutely. I have visited some superb residential homes in this country, and I have also visited some dreadful ones, so on a statement about them being the worst in Europe, I wouldn’t be able to answer totally. But I do think that there are some places in Europe where, for example, there is multiple occupancy in care homes. In the UK, that isn’t the case, and that is something that we should hold on to—having a personal room for residents. There are places where we can go that would be worse than the current situation.

However, there are real problems in the residential sector that I have seen—things that do not just relate to internal organisation, which the CSJ thinks needs considerable reform. I would like later to bring the Committee’s attention to a new model that we are particularly enthusiastic about. I have been to homes where 99-year-old men with comorbidity said that they had not seen a GP in two years. Of course, when you are doing research, you are always wondering, “Is this just a one-off, or is this related to more of a trend?” From the work that we have done with the British Geriatric Society and other organisations and homes, particularly in the inner city, this is a problem that we are seeing again and again—GPs are not going into residential and nursing care homes, and residents are suffering as a result. They do not go in because, as one GP who is a medical director of a London borough’s PCT said, they are a “clinical iceberg”—they do not know where to begin and they are not commissioned to do it.

The arrangements we know about, as a result of that, are either that providers cut their losses and pay extra money to the NHS, thus double charging basically—so £10,000 for one afternoon session a week—and that is what produces the best results because you are
having the regular presence of a GP, or that they go without and the result is high rates of emergency admission to hospital. There are problems with the residential sector that are internal to it, but there are also problems with the residential sector that relate to the NHS and to the regulatory framework.

Q507 Rosie Cooper: You have just described what is, in essence, paragraph 9 of your evidence. I would say that the fact that you need a defined GP is not only relevant to care homes but to long-term care for patients who are maybe living in housing association or other accommodation. How do you think that changes to social care, but also the NHS reforms, can actually deliver? Looking through changes in GP contracts, if you like, how do you see the problem that you have just outlined addressed in the current climate?

Dr Mumford: We think that the proposed reform—the Health and Social Care Bill—could present opportunities to improve the particular issue of GPs going to care homes. That is because we think that there should be an alignment of single practices to single homes, with opt-out clauses and possibilities for residents who want to remain with their family doctor. That is most likely to happen when it is commissioned by GPs and when GPs see the incentive to do it.

I am not an expert on the frameworks around GP contracts, but we have received evidence from multiple medical directors of PCTs saying that the 2004 contract does not incentivise GPs to work in this context. I know that it is a historical issue in terms of this being a group of people who used to be looked after in hospital and are now looked after in the community, and that transition and that shift has happened over the past 20 years, but we think that it has to be higher up the job agenda for GPs. We think that this could be made possible by GPs being more empowered to act through this Bill.

Q508 Rosie Cooper: Sarah may be able to help a bit with this, but let me just make one final comment. I know of someone who went into a nursing home—a residential home and thereafter a nursing home. They were obliged to change from their family doctor and they were registered with another practice, but when they needed to see a doctor, they saw a different doctor and one who did not read, or did not know, any of the medical history. Every time they visited, the doctor changed all the drugs that the person had been on for 10, 15 or whatever it was years, at a stroke, saying “Oh, they don’t need that now—change this”; and a new doctor comes, saying, “Change that.” What you are describing may sound good, but the truth is that, unless there is some continuity, even there, people just disregard what has gone before.

Dr Mumford: The transition is a key point but, counter to that, I have seen superb ways of working, for example, in Peterborough, where a GP felt that her practice was failing the local community of residents in nursing and residential homes, as there were multiple doctors going in from different practices. The start was to align one practice to one home; and then you have got a problem about which doctors are within it. Once they had achieved that, which obviously needed a sympathetic PCT which she had in Cambridgeshire, then she—this is Dr Gillie Evans, whose case study is noted in *Age of Opportunity*—realised that she needed to lead by example and take the most difficult specialist nursing home, and she would be the doctor who went in there every week. Other of her GP colleagues went in and looked after the other care homes. The point there about the transition was that the handover from the nurses is dramatically improved. She was able to introduce syringe drivers, so the specialist nursing home is basically a hospice in this context.

What we think is that you can find excellent models of best practice, and I am sure that the Committee has heard lots—or perhaps few—.

Chair: We have heard some.

Dr Mumford: There is structurally something whereby this could become rolled out on a more widespread basis. We think that that might be possible in the new reforms.

I will go back to your direct question, Ms Cooper, on the issue of what happens if you transition from a family doctor whom you love to a new practice that looks after that particular home, which you do not know anything about. We think that you could have an opt-out to stay with the family doctor, as long as the family doctor behaves differently from how the majority of GPs in this country behave in relation to their residents in care homes. I say the majority, because there are excellent examples of family doctors who do not, but I think that is how it could be solved.

David Orr: A rider to that: for us, one of the key questions about the Bill that is presently being debated, and about GP commissioning, is the extent to which it solves the existing problem of lack of access to GPs for people whom you might describe as being deeply excluded. This is a major problem at present. People who are homeless find it very difficult to access GP services and, as a result, they make hugely disproportionate and very expensive use of hospital services. A whole range of other people find it difficult, just on a day-to-day basis, to access GP services. If we are to start from an assumption that the best way of keeping the nation healthy is by preventing illness and by being able to intervene at the earliest possible time, this is an issue that has to be resolved.

Q509 Valerie Vaz: Can I just add something slightly different? Most of the debate has been about the fact that there will be a demographic change and lots of elderly, and about how we get them to pay for it because they own these houses. I do not know whether either of you has statistics about how many people we are actually talking about who live in these houses who can pay for their care. You mentioned that half are over 60 in housing associations. Do you have any figures for that?

David Orr: People who are living in housing associations are renting their homes in the huge majority of cases.

Q510 Valerie Vaz: Exactly. So my point is that they are still going to be an issue.
David Orr: They do not have the capital asset of a home to move back to. The issue about how care, of whatever kind, for those people is paid for is an acute one, because for owner-occupiers it may be an unpalatable possibility but at least there may be equity in their homes that they can use. People who are renting do not have that. Unless they have savings built up, they do not have the mechanism to pay for their care. Although the Dilnot report has had a range of different responses, one of the things that seemed to us to be sensible about it was that if you are to create a new system that depends to any extent on insurance, there has to be a mechanism for limiting the overall exposure of the insurers. That is what Dilnot does, and it seems to us that at least that mechanism is worth exploring further.

We also believe that it is possible to explore equity-release schemes for people who do have equity in their homes. One of the mechanisms might be for homes to be sold to housing associations, thereby releasing the equity and allowing the person to continue to live in their own home. It seems to me that if we are to resolve this conundrum, we absolutely have to have every option still available and not have closed down options in the discussion about how we pay for social care.

Chair: The question is around the statistics of the number of people in housing associations or in care homes?

Q51 Valerie Vaz: The problem is that the debate seems to be about how we get the elderly people to pay for it. Now there is a chance to have a much wider debate about how we treat our elderly, and this is a chance for everyone to come in. We do not see them just as bed blockers, and consider how they pay for it and how we save money. If we solve the problem of how we treat our elderly in society, perhaps we can release schemes for people who do have equity in their homes. One of the mechanisms might be for releasing the equity and allowing the person to take responsibility for the way that that particular Green House is run, and by also allowing them to take charge of cooking the meals and doing the laundry, you make huge staffing efficiencies, so that there is not actually any more hour per resident in terms of the staff labour cost, but it is for the same cost. They have seen extraordinary results from what they have achieved because of these two dramatic innovations at the heart of this new form of care. As I said, this is not just a bright idea. It is being backed and rolled out across the US.

Q512 Valerie Vaz: Which brings me on to the future. You have seen the past, the present and the future: could you describe this new model that you have seen?

Dr Mumford: As part of our review, we conducted an international visit to the United States to see a model of nursing care—this is an important point—that is residential, like a nursing home. The model was invented by Dr Bill Thomas. It is not just a brainchild; it actually exists. There are 127 Green Houses in the US with 250 in development. Based on the assumption that, even if we get much better at providing care in the community, which I know Mr Orr has been speaking about for 20 years—that has to happen and our report gives a lot of attention to that—the prognosis for dementia and clinical dependency, and the consensus that at some point it becomes difficult to look after a clinically dependent older person in their own home, means that the need for intense-care settings is not going to go away. The need for care homes is not going to go away, so for all the policy attention to be focused on keeping people in their own home for longer misses possibilities for reform of the long-term care setting. Thus it becomes absolutely vital that we dream a different future for residential care, particularly nursing care. The Green House model presents a new way of doing that, and the innovation lies in two things. First, the reform of design. These Green Houses are self-contained buildings for nine to 12 people with about two staff members looking after each home. Their kitchen is not downstairs or siphoned off but is actually at the heart of the home. There are no clinical corridors and the rooms are off the central area. The design is half of it. The second half of the innovation is around the staffing ethos. Basically, by cutting out middle management, the key thought is this: the staff in the care home context are bigger than the roles that they have.

By empowering the staff to actually take responsibility for the way that that particular Green House is run, and by also allowing them to take charge of cooking the meals and doing the laundry, you make huge staffing efficiencies, so that there is not actually any more hour per resident in terms of the staff labour cost, but it is for the same cost. They have seen extraordinary results from what they have achieved because of these two dramatic innovations at the heart of this new form of care. As I said, this is not just a bright idea. It is being backed and rolled out across the US.
Q513 Barbara Keeley: You said “nursing care”. Where is the medical element of that?
Dr Mumford: The medical element is the two care staff—for reasons that I will not go into they are called “shabbaaz”. They basically want to create a new word, because they think it is demeaning as a job role in western societies. You have two of those for the eight to 12 people. Because you have a number of those different homes in the same place, even though each is run differently, for each of the two homes you also have one nurse attached who would be going from those two homes, and so the nursing element is there and is crucial. For us, the recommendation that goes along with new models and allowing for new models to take place and reform of long-term care, and dreaming a different future for it, is around the regulation.

At the moment, nurses have to be on site in nursing homes. We already made a recommendation in “Age of Opportunity” around a consensus forming that the distinction between residential and nursing is becoming spurious, because the clinical profile of people in residential is coming to resemble that of the people in nursing homes. Therefore we think that the nursing money that the NHS allocates to people in nursing homes should be allowed to follow the patient or resident into residential homes. That means you have to decouple it from a requirement that there be nurses on site in nursing homes, because you would not expect all residential homes to have nurses, which means we need a new role of nursing from that which, obviously, is current. Basically, that would mean changing the law—a regulatory change to allow there to be new models of doing this.

Q514 Barbara Keeley: I wouldn’t disagree with the vision that you have described for care homes, but it seems to me about a million miles away from the reality of where we are in terms of funding. Some £1 billion has gone out of adult social care funding over the last year, and more cuts are expected this year and next year. Care homes are struggling to even survive, the last year, and more cuts are expected this year and next. If we had a more flexible system, we could probably look at extra care housing that would be significantly less costly in terms of the public capital. Yes, it would require redesigning. We think that there are possibilities through the Homes and Communities Agency and through the way that central Government work to incentivise local provision. We think that that could be a possibility, I have seen cases across the country where sheltered homes have been retrofitted into extra-care housing, for example. That would be something where that as well as retrofitting to extra-care housing, retrofitting to Green Houses could be a possibility. I really think that the key point is the revenue. If it were shown that the running of it—with the downward deflation on pricing by social services departments—was much more expensive, there would be a real force in this current environment of how we could possibly think of new models that may be better but a lot more expensive. I draw the Committee’s attention to a peer review journal of the American Geriatric Society. It has written up the costing implications of the Green House model. I would be happy to supply this as a note to the Chairman. It actually shows that it is not more expensive to run them, because you are redesigning where staff and labour cost is allocated. You are basically getting much more face-to-face contact between the care workers in the Green Houses and the residents, because it is a smaller context. You are taking out the middle management. For example, if you calculate that an average nursing home bed in the UK costs £650 a week and, therefore, £2,800 a month, which is say £4,000, that sits right in the ballpark of where the reimbursement for the Green Houses comes from, because half of all people in Green Houses are on Medicaid. It is state reimbursement money that they are looking for. It is non-profit. It is looking for the kind of people who would be provided by the state in a different way that the US states do it. It is not an upper end brass and glass provision, which is really the key point for thinking about why this could be relevant to our context.

Q516 Chair: If we had a more flexible system, we could probably look at extra care housing that would be significantly less costly in terms of the public revenue that would be required. Instead of having three or four classifications, we would have a continuum of different models of care that were more appropriate to individual sets of circumstances?
David Orr: Which is precisely what we need. A lot of that is covered in a publication that we produced last year, called “Breaking the Mould”. If you haven’t already seen it, please take a copy. I can circulate others. It covers quite a wide range of ideas. Some of it envisages the future happening now. We just have to be clear about the funding challenges that there are. Like it or not, the Homes and Communities Agency’s capital funding is two thirds down on what it was in the last comprehensive review period. It meant that the mechanisms by which housing associations produce new homes are based on revenue subsidy, higher rents and more housing benefit. That will not
work for capital investment in specialist residential accommodation. The incidence of new specialist residential accommodation in the present framework is miniscule, partly because the capital is not there, but partly because no one is confident about the revenue funding being there to support specialist capital provision. We have to be very thoughtful about how we make this whole system as flexible as it possibly can be. Dr Mumford’s idea is potentially worth further exploring, but it is about having a wide range. We call it “Breaking the Mould”, because we have to think differently about how we do it, and I hope that there are some useful examples.

Q517 Grahame M. Morris: While you are on this issue, one aspect of Dilnot is capping living costs of between £7,000 and £10,000 a year, which has revenue implications. What is your view on the downside of that aspect of Dilnot’s findings?

David Orr: Honestly? We have to see Dilnot as the start of a negotiation. If you accept the basic principle, you have to get drilling down into what numbers will work and what numbers will not work. In many cases, those will be sensible. But people’s needs change, so how do you assess what constitutes a housing cost, a support cost and a care cost? That was really what the Supporting People fund tried and, in the main, successfully delivered in doing. The Government have protected that, but because of the exigencies of local government at present, the amount that has gone into local government is not coming out for the provision of new, supported housing.

Some 75% of our members who are in this business say that they expect cuts of 12% or more. Nearly half reckon more than 20%. There are some local authorities cutting by 40%. Provision is going, and the way that commissioning is working means that there is an expectation that costs will be squeezed and squeezed. That is happening to the extent that one or two housing associations, which care about the standard of living of the people whom they employ as well as about the care that they can provide, are saying, “We are not going to do this any longer, because we think it is taking us to a place where we cannot provide to the level that we want.” We have to think very carefully about the consequences of some of the squeeze that is happening at the moment and see if we can think creatively about different ways of funding it. If we are ever to get insurance in, you need to have a cap on the exposure to the insurers. That’s where Dilnot is right.

Q518 Dr Wollaston: I want to touch on a couple of things. First, to Dr Mumford, does the level of dependency in these Green Houses reflect the level of dependency that we see in nursing homes in the UK? It strikes me that the staffing model means that their staff are doing effectively what carers do in the UK—they are doing the shopping, the cooking, the cleaning and the caring. But if you’ve only got two for a ratio of up to nine residents, that is presumably not going to be effective if they have got high levels of dependency. In other words, is what you are classifying as nursing dependency equivalent to what would be nursing dependency in this country?

Dr Mumford: I would be happy to find more of the evidence base around the profile, but yes, it is the same clinical dependency profile. When I visited Albany in the state of New York, the Green House I visited there sat alongside what the American term for our residential is, which is assisted living. Those two facilities sat alongside each other, and it was very obvious that, having seen the difference between some of the self-payers, for example, in the care home that I volunteer in, in London, and nursing home patients—in this country, the difference is merging—the self-payers in that context, in a residential home, are very different from the nursing home patients in a UK context. That difference was similar to the difference between assisted living and the Green Houses. The assisted living was that there would be high rates of dementia, but in terms of other things, in other levels of clinical dependency, some of the people in the Green Houses were really dependent. Again, on the concentration of staff there, of those shahbazim, by increasing the time spent—it is a smaller context, and it is how they feel that succeed in that—they would be the first to stress that they are dealing for a typical nursing home population group.

Q519 Dr Wollaston: Thank you for that. Coming back to David Orr, can I ask what the under-occupation rate is in housing associations? I wonder whether one of the models for funding the higher quality of housing needed is to persuade people to vacate under-occupied properties, so that those with larger families can be housed. Is that one of the models that it relies on, or do you think that we need to return to a previous funding model of capital funding?

David Orr: First, I think we have to think quite carefully about the nature of the offer that will persuade people that they want to move from what has been their family home. At present there are many people living in three or four-bedroom homes who are resistant to moving, because they have lived there for the past 30 years there and their children have grown up—all the reasons that people become attached to a place, all the memories and all the rest of it. Our response to that has tended to be to offer poor quality, one-bedroom accommodation. People are resistant to moving to that.

What we ought to be doing is offering high quality accommodation of at least two bedrooms, so that the grandchildren can come and so that there is an offer that says, “This will improve, rather than diminish your quality of life.” We have not been very good at thinking about releasing the capacity by improving the offer that we make to people to move out of those properties. There are a number of organisations, particularly housing associations, that are doing everything they can to make the process of moving as easy and straightforward as they can, saying, “We will sort it all out for you. We will provide the moving. We will do everything that we can. We will pay for all of that.” Many people like and welcome that.

We know that when people have the opportunity to move into high-quality accommodation in extra care
or a retirement village or whatever, they are very happy with what they have moved to. The concern is that they are being pushed into a small, one-bedroom place and “I’m not going to go” is the response that you get. There is capacity, but we have to think about it in a way that does not lead to the individual or the couple concerned feeling that they are being penalised for becoming old.

Q520 Dr Wollaston: Are there some examples of this where it is happening much better in some parts of the country than others?

David Orr: Yes. We can provide you with some examples of where that is happening.

Q521 Dr Wollaston: How do they fund it? Why are some areas successful and other areas unsuccessful?

David Orr: This is a complicated business to do with the way in which housing associations and local authorities debate the use of the existing housing stock. If you have a local authority that always wants to ensure that as soon as a vacancy arises, someone is moved in from the waiting list into that vacancy, it is very difficult to have the kind of flexibility that we want to see, where, when a vacancy arises, they would think, “Who in our existing stock would this vacancy most suit and, then, can we move someone else? Could we use a vacancy to create a chain of three, four or five different moves that benefit a whole lot of people?” At the end of that, you could say, “Here is the vacancy that we can refer back to the waiting list.” The tendency is that they go straight to the waiting list and the local authority says, “Right, it is a two-bedroom flat, so we will allocate that to a couple and a child.” We have talked about flexibility in this a lot. Flexibility is absolutely the key in dealing with all of this. People have to have the ability to manage the estate much more flexibly than has been the case.

Q522 David Tredinnick: I want to change the subject slightly and talk about home adaptations, which touches on something that you said earlier about grab bars. I have a couple of questions. To what extent are local authorities and the National Health Service pooling budgets to create home adaptation services to support those who want to stay in their own home?

David Orr: Not enough, I would say. There is a degree of frustration out there, which you referred to earlier, Ms Cooper, at how simple and straightforward it ought to be, but how difficult it is to get the OT visit to get the process under way, which allows the assessment to be carried out and then allows the investment to be made.

Q523 David Tredinnick: So, to go back to your earlier point, is this where you see the Health and Wellbeing Boards coming in with new ideas?

David Orr: This is a possible place. It is the kind of subject that may be part of the discussion at a slightly more strategic level. Again, there are one or two examples of places where this whole process works extremely well. We can provide evidence of those for the Committee. Part of the reason for the frustration is that everybody looks at it and thinks, “It really needn’t be this difficult. Why is it so difficult to organise this?” Sometimes it is something as basic and straightforward as the money being there, but because the rules said that you have to have an OT and you cannot get the OT for a year and a half, nothing happens. That is the kind of thing that we have to get past.

Q524 David Tredinnick: Last question. When the Committee went to Carlisle, we were shown some brochures about colour coding of homes where doors had been painted red and plates bright blue and other simple striking colour schemes used to help patients—perhaps, residents, I should say—find their way around the home. I was thinking about what you were saying about grab bars earlier on. This is really a development of the grab-bar theory. It is incredibly simple and it appeared, from what I heard, that it enabled people to move around their home safely and thereby stay in residence, rather than in hospital, for a longer period of time for a minimal cost.

David Orr: That is absolutely right. Both inside the property and where people are living in extra care or retirement villages or whatever, the incidence is growing of colour coding of floors and making it easy for people to navigate their way around. The level of learning and expertise on that is growing rapidly. Certainly what I see is that extra care facility that is now being built will have that thinking as part of the design. I think there is real progress happening there.

Q525 Dr Poulter: I want to pick up on some of the issues you have raised about local authorities. You say that some local authorities do things well but there is also a concern about the intransigent attitudes that may exist in some local authorities. We have talked about Health and Wellbeing Boards but how would you like to see those attitudes broken down? What mechanisms could be put in place?

David Orr: Let me start by being generous and saying that I think local authorities are under enormous pressure at the moment. The range of demands that are being made of them at the same time as they are having to make significant cuts to their spending has put them under considerable pressure. Some of the consequences of that are about a degree of entrenchment—people wanting to hold on to and protect what they need. This question, not just in local authorities, it is true in housing associations, the health service and elsewhere, always comes down to local leadership and the extent to which, at a local level, people are prepared to share. Community budgeting: we ought to be seeing more of that. It is a mechanism that works. We know that it works. I know the terminology keeps changing but I am referring to the kind of total place thinking that says, “Let’s look at this place as a whole and try to work out how we can invest in it in a way that makes the most sense.”

Q526 Dr Poulter: That is a good point, but nevertheless having an acceptance—some members of the Committee agree fully with what you said—that housing and having housing that is fit for purpose,
Adaptable and future-proofed as well, to support people as they grow older is an essential part of preventive health care and good social care. That is the point that you made. But that is not a view that is widely realised by local authorities in general and by the NHS in getting it to happen on the ground. You have the Department of Health on the one side and the Department for Communities and Local Government on the other. But this issue, because it is housing, perhaps sits in governmental terms with the DCLG. Is there anything you could say in terms of pushing this agenda forward either at a local level or a national level that would be useful in terms of raising that awareness about holistic and preventive care?

David Orr: Practical things—there is a whole of lot of land sitting there that is capable of being built on, which would help to ease the housing crisis and, if it was health service or local authority land that we were building on, there is a huge amount of willingness in housing associations and elsewhere to talk about what is most needed. The experience of housing associations talking to the health service about their land is: “We want you to build things that work for the health service but we are going to sell you the land at top dollar because we need the money as well.” That is not a sensible starting point for negotiation. A lot of this operational stuff at a local level, yes, it does depend on the quality of local leadership, but there is not a strategic environment that nurtures the idea that we do this best if health, housing and social care are part of the same conversation at the same table as a matter of course.

Q527 Dr Poulter: How would you create that strategic environment? That is what I am trying to drive at. What would you do, what would you say, what could be done to create that? Obviously, talking about partnership—

David Orr: We have suggested that the Bill should have a requirement that there is a housing voice on Health and Wellbeing Boards; that there should be a housing needs assessment as part of the health assessment. You cannot look at how someone’s overall health is going to be managed unless you are clear that there is a safe and secure home for them to live in. We think that you can write that into the legislation; not writing in the outcomes but the mechanisms that ensure that at least the conversation is required to take place.

Q528 Dr Poulter: One final question. We obviously have unitary authorities and we have other set-ups such as two-tier authorities. Health and Wellbeing Boards are to be run by the upper-tier authority, obviously by the unitary authority, but where there are two tiers of local authorities, the lower tier does not run the Health and Wellbeing Boards but is actually responsible primarily for housing and housing associations as well. Is that of concern to you in this context?

David Orr: Yes, I think it is. I think two-tier local government is quite often something of an inhibitor of effective communication. Because, if you are a housing association having to engage at both tiers and you are engaged in housing and support then the housing is in one local authority—district council—and the support and whole discussion about care is at a county level. That is already something of a complicating factor. How the Health and Wellbeing Boards are constructed means that they will be at the upper tier of local government and I think that is probably right. That is the scale it needs to happen at. I was intrigued by the way you phrased the question, when you said that it would be the upper-tier level that runs the Health and Wellbeing Boards. I hope they will see their job as hosting the Health and Wellbeing Boards and making sure they run themselves. I think this is part of the difficulty. If local government believes that it owns and is therefore responsible for all of the outcomes of the Health and Wellbeing Boards, they will not be as effective as where local government says, “This is a mechanism by which we bring a range of people together to come up with some solutions.”

Chair: On that note, I am going to say thank you very much for your evidence and contribution. You have given us plenty of food for thought.
Tuesday 17 January 2012

Members present:

Mr Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Barbara Keeley
Grahame M. Morris
Dr Daniel Poulter

Mr Virendra Sharma
Chris Skidmore
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Paul Burstow MP, Minister of State for Care Services, and David Behan CBE, Director General of Social Care, Local Government and Care Partnerships, Department of Health, gave evidence.

Q529 Chair: Good morning. Welcome to the Committee. As you know, we have been taking evidence now for some weeks on future policy developments affecting social care—the structure of the way social care is delivered, the way that it relates to other aspects of care in the health service and, indeed, in social housing and, importantly, how it is funded now and in the future. We would like to ask a series of questions around all those issues on policy, structure and funding.

Will you begin, Minister, by setting out where the Government are, in terms of their own internal deliberations on the issues—both the policy questions and the funding questions—and say how the Government plan to take the process forward from today?

Paul Burstow: Yes. Thank you very much. We are very pleased that you are conducting this series of hearings and plan to publish your report ahead of the publication of the White Paper. We see that as a valuable contribution to the process of the policy formulation itself and to helping us land a set of reforms that are long overdue in the area of social care.

It is best to set a broad context in that, when we came into office as a coalition Government last year and worked on developing the more detailed coalition programme for the Government that was published after the coalition agreement was signed, there was an agreement across the Government that we needed to move swiftly to establish a Commission to look at the question of funding reform. We proceeded to get terms of reference agreed and the appointment of that Commission prior to the summer recess of 2010.

Andrew Dilnot and his team have produced an excellent report, which I am sure provides a lot of valuable contribution to the process of the policy formulation itself and to helping us land a set of questions around all those issues on policy, structure and funding.

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Andrew Dilnot and his team have produced an excellent report, which I am sure provides a lot of areas for discussion later in this Committee today.

But, of course, Andrew Dilnot's report was only ever one part of a complex jigsaw puzzle. Another important element of that jigsaw puzzle is the work that the Law Commission was commissioned to do in 2008. It reported in May 2011 and, again, has produced a very useful set of proposals—76 recommendations in all. I guess that the third element in our approach that we took in leading up to the spending review in 2010, is that we as a Department saw the investment in social care, the protection of social care and the protection of the vulnerable as a key public policy priority for the Government. We reflected that in the decision to ensure that, by the end of the spending review, there will be an additional £2 billion a year going in to support social care through the two routes, which I suspect we shall explore in more detail. That is broadly where we are. We are obviously in the middle of a White Paper drafting season and the necessary cross-Government discussions that take place as part of that process.

Q530 Chair: May I ask you a few process questions and get them on the table at the beginning? You said that the Government are in White Paper drafting mode. Are we anticipating a single White Paper that covers both the policy and the funding questions? Are we expecting two White Papers? What sort of time scale are we expecting them in?

Paul Burstow: No. When the Secretary of State made his statement to the House shortly after publication of the Dilnot Commission’s recommendations, we made it clear then that we would publish a White Paper covering law reform and reform associated with the outcomes from the “Caring for our Future” engagement that concluded in December, and that we would publish a progress report on reform. It is our intention that those two documents are published at the same time.

Q531 Chair: Published on the same day, and in what sort of time scale?

Paul Burstow: We are talking about publication in the spring. There is no firm date printed into a grid, as it were, at the moment, but the spring is the time when we wish to publish the package.

Q532 Chair: I think I am right in saying that today cross-party talks are beginning between the major parties about funding options. How do you envisage those talks playing into the process?

Paul Burstow: All I can really say about those talks is that they are happening. We had our first meeting today. It was a constructive meeting. What we and the official Opposition have agreed is that we are not prepared to offer a running commentary on those discussions, but they are looking at issues of funding reform.

Q533 Chair: Do you envisage their being concluded before the White Paper and documents are published?
Paul Burstow: I think everyone involved in those talks would hope that that is the outcome that we achieve.

Q534 Chair: I accept that it is not yet anybody’s decision, but if it were decided to implement Dilnot as he recommends, would that require primary legislation?

Paul Burstow: It would require some primary legislation to implement some aspects of the Dilnot recommendations. There are 13 recommendations in his report. A number of them play across into the Law Commission’s recommendations: eligibility, assessment and so on. Yes, there are areas that would require legislation.

Q535 Chair: So should we expect that there will be primary legislation proposed by the Government in the next Session of Parliament?

Paul Burstow: What you can expect is that, in the White Paper, we will give our response to the Law Commission. In a way, the Law Commission report is the seminal piece of work around law reform. Indeed, it enables us to progress a number of policy issues, which, again, I expect we will explore—not least, embedding in a system that was designed in the 1940s and rather grounded in principles that were established prior to the 1940s. On that legal framework, it is very hard to stick the whole set of reforms that successive Governments have tried to apply to it. Law reform is actually rather key to delivering a lot of the changes around personalisation and so on that we want to see.

Q536 Chair: Next Session?

Paul Burstow: That is a matter for the Public Bill Committee. It makes these decisions, not individual Ministers in Departments.

Q537 Chair: But sometimes the Government can announce their conclusions.

Paul Burstow: I am not in a position to announce a conclusion today, I am afraid.

Chair: Okay. Thank you. Any other process points anybody wants to raise?

Q538 Dr Poulter: You made the point that you will not have necessarily come to a firm conclusion on the funding when you publish the White Paper, but, if I was understanding what you said correctly, there will be an indication of what your future direction of travel on deciding funding is.

Paul Burstow: What I said is that there will be a progress report. What I have not said is that we have already predetermined what the conclusion of that progress report will be. We are engaged in a series of processes, both internal Government ones and discussions with the official Opposition.

Q539 Dr Poulter: So alongside the White Paper, there will be a progress report on funding as well, and the conclusion on funding will not be part of the White Paper itself.

Paul Burstow: That is correct.

Grahame M. Morris: Can I just—

Chair: This is a process.

Q540 Grahame M. Morris: It is, absolutely. It is a question rather than a comment. Given the crisis we are facing in social care, the Committee has received ample evidence in respect of the imperative nature of addressing the issue. Are the Government arguing for legislation within this Parliament? I am left with the impression that we do not know what is going to happen. Are you pressing the case to have time set aside for primary legislation to implement Dilnot in this Parliament?

Paul Burstow: The Government’s position is clear: we want to see legislation introduced into Parliament at the earliest opportunity. What I cannot announce today, because those decisions have not been made, is whether it will be a second Session Bill or not. The intent is very clear. We want to legislate on social care reform during the course of this Parliament.

Q541 Barbara Keeley: Minister, you mentioned a jigsaw puzzle when you talked about the Dilnot report and the Law Commission, but there is also the current funding gap and the growing level of unmet need. In fact, the King’s Fund estimates that nearly 900,000 people are being left without basic care. Most commentators do talk about our social care system being in crisis. Could you say what the Government will be doing immediately to address this current funding crisis to avert the obviously potentially catastrophic impact on people’s lives and the NHS?

Paul Burstow: We are doing and will continue to do a number of things to support the social care system that we currently have while we move to a reformed system. That started with the spending review decisions that we took in 2010 and the decision that, over the life of this Parliament, we will be investing an extra £7.2 billion in support of social care. That will come in two ways: first, through the local government funding formula settlement and, secondly, through an unprecedented transfer of resources from the NHS to support social care. I am sure that the Committee has been looking quite closely at issues of integration. We are seeing that integration is very successful at brokering new relationships between the NHS and local authorities, so that we can better use the resources across the system.

We are also looking very critically at how we can improve productivity in the system. That is why we are, for example, working with the Local Government Association on a programme that it has constructed to support local authorities in addressing productivity challenges. Indeed, the previous Administration published a report looking at the disparity of costs across the system. There are still disparities across the system in terms of the relative expenditure on residential care, for example, and opportunities to the system.

Finally, we know from the research that has been done that, for example, investment in re-ablement services can significantly improve the quality of life for individuals and release resources. They can save costs in the system. We have recently announced a significant roll-out of telehealth and telecare. We know that when those are well deployed as part of system change, they can release resources.
Q542 Barbara Keeley: That is interesting. You have mentioned £2 billion a number of times in Parliament. How do you respond to Andrew Dilnot, who said, “There is no doubt at all that the additional money you provided to local authorities has not found its way through to social care.”? Clearly, there is a lot of monitoring and evidence on that. Perhaps you would like to update us. The Alzheimer’s Society told us that a number of PCTs—two-thirds, I think—don’t know where the dementia strategy funds were spent. The Princess Royal Trust for Carers said, “The £400 million earmarked for carers’ breaks has not gone to the right place.” That is an issue that you campaigned on in Opposition. How can you improve social care when you are actually unable, particularly now that there is no ring-fencing, to channel money to the correct part of the system? How can that work? You don’t have the say over where that money goes—whether it’s in PCTs, clusters or local authorities. They have the say and you do not.

Paul Burstow: There is a lot in there, including carers, dementia and the overall budget. Let us be clear that the total spend on social care in England is about £14.6 billion. In terms of what the Government could or could not ring-fence, it would not be that whole pot. There is still an awful lot of discretionary spend that the local authorities in discharging their statutory duties would have decisions over anyway. We need to keep reminding ourselves that these are local authority services. We are talking about locally elected bodies that are responsible and accountable to their populations for the decisions that they make. You asked a question about the allocations. What we do know, and I will be happy to supply notes to give details on this afterwards, is in respect of the transfers of moneys from PCTs. The most up-to-date information that we have with regard to the £648 million that is being transferred is that 18% is going to early supported hospital discharge schemes—this January, we announced an additional £150 million to support additional investment there—8% is going to support intermediate care services, 8% is going to early supported hospital discharge schemes, 18% is going to supporting additional investment in re-ablement services, 10% is going to support intermediate care services, 8% is going to early supported hospital discharge schemes, 18% is going to support additional investment there—8% is going to its greater crisis response and 38% is going to other services such as telecare, community equipment adaptations, mental health and so on. I will come on to dementia and carers, but that is where we are with the NHS money generally.

Q543 Barbara Keeley: It would be helpful to the Committee and as you embark on your cross-party talks to understand what is the gross figure or the current gap in funding. How big is it? We know what the Dilnot recommendations are. There is talk of other figures—£5 billion, £6 billion, £7 billion—to meet unmet need and to meet the current crisis. What is that figure?

Paul Burstow: Let me try to respond to that. In the work that was done leading up to the spending review, the question that we were asked by the Treasury and that we answered in the spending settlement was how we close the funding gap during the life of this spending review. The judgment that was made on the basis of the information available to us was that that gap gets closed by the money and by a rigorous programme of efficiency. Indeed, the King’s Fund—

Q544 Barbara Keeley: Can you say what the figure is, please?

Paul Burstow: The point I am making is that there is no gap. There is no gap in the current spending review period on the basis of the moneys that we are putting in plus efficiency gains through local authorities redesigning services. The King’s Fund in its work identified even with the worst case scenario that it required 3.5% efficiency savings. We don’t accept the position that there is a gap. We have closed that gap in the spending review. On the issue of unmet need, I am yet to find any agreement among academics on a definition of unmet need. Even the personal social services research unit says that it is a very hard area to navigate and come to any firm conclusions on.

Q545 Barbara Keeley: You are embarking on trying to work on the future funding and there is this crisis. It seems to me that if you do not have a method of getting to unmet need or knowing what unmet need is and you don’t believe there is a gap when almost all external commentators say that our social care system is in crisis—

Paul Burstow: There are three things here. There is the current spending period and what the Government have done to address the pressures that we identified at the beginning of the spending—hopefully, I have just outlined those and we amplified them in the submission that we provided to the Committee. There is then what we need to do to address the next spending review period. We have not started the next spending review yet so in a sense that is the next piece of work. There is the question about how you reform the funding system. Andrew Dilnot was not asked to look at the quantum. He was not asked to look at the total amount of money going to the schemes. He was asked some very specific questions about how we address the balance of the relationship between the state and the individual in terms of what each contributes to support their care needs.

Q546 Barbara Keeley: Indeed. But you can’t build Andrew Dilnot’s recommendation on a system in crisis where there is a gap. Is it your contention to this Committee that there is no gap, that there is no problem and there is no issue with the current system? You seem to be saying that you don’t think there is a gap currently.

Paul Burstow: It is a mistake to generalise and say, “The system is in crisis”.

Q547 Barbara Keeley: That is what people say.

Paul Burstow: Let me give you a couple of examples of what I mean. Indeed, Julie Jones, in the evidence she gave you, made the observation that it is quite surprising how, with relatively similar levels of need, relatively similar levels of problem and challenge in the social care system, different areas are responding to it differently and therefore mitigating potential problems. Indeed, the report that was published by Scope which looked at these issues also came to a similar conclusion that there was not a direct
correlation in terms of the investment that was being put into the system and the outcomes that were being achieved. They outlined some of the reasons for that and it was a very interesting report for that reason.

Q548 Grahame M. Morris: On the same theme, I want to take issue with the Minister’s response there and point out that there is an inconsistency with evidence that the Committee has received from the Local Government Association and from the directors of adult social services. You mentioned their commitment to efficiency savings and the accepted 3%, and your Department concurred that that was achievable. You mentioned £150 million for re-ablement, which we recognise, but still the LGA estimate that they face a funding gap in the order of £6.5 billion in 2011–12. That reflects the difference between what local authorities in England need to spend to maintain front-line services in their current form and the income they can get from the council tax, fees, grants, business rates and so on. There seems to be a difference of opinion there as to what the current situation is as expressed by the people who are delivering it on the ground and the Minister’s response to the Committee today.

Paul Burstow: I take that as a statement—

Q549 Grahame M. Morris: I am asking you to challenge it.

Paul Burstow: You are entirely right that there is a difference of opinion. All I am saying is that the difference of opinion is not solely between the Government and the Local Government Association and other witnesses during your hearings. The difference of opinion is broader than that. I referred to other witnesses that you have had before your Committee—Julie Jones in her comments and the work that has been done by Scope. This is not a simple issue of how much resource the Government are putting in—we are putting in £7.2 billion over the life of this Parliament; it is also a question of the priorities they are making in terms of the priorities they are making for investment in social care. It is quite clear that one of the challenges over the life of this Parliament and into the next is how you manage the demand in the system. One of the issues that you have been looking at and which we are looking at in the context of our White Paper is around prevention and early intervention, which are key to managing demand pressures in the system.

Q550 Rosie Cooper: Grahame has substantially asked what I was going to ask. If I was a member of the public out there watching this this morning, I would be filled with despair. They know they cannot get the services. Local authorities are desperately trying to get the funding to ensure that they can deliver basic services. You are saying that there is no gap. You are saying that financially you have put extra money in, but you have also acknowledged that you cannot ensure that the money goes where it is intended. It is very clear that money put in that does not have some real direction does not reach the parts it should. With all due respect, Minister, if you were a member of the public who desperately needed this service and who had listened to the exchanges so far, wouldn’t you think we were just talking a good game and not getting anywhere?

Paul Burstow: I don’t know and obviously I would be interested to see how people do read this hearing today. My response to these questions is very clear: there need not be a gap in funding if local authorities take the sorts of efficiency steps that the LGA has accepted are possible—a 3% level of efficiency. There is no gap opening. The issue is about whether each local authority chooses to do that; individual local authority choices differ from one part of the country to another, as evidenced in the work by Scope and Demos and by comments from some of the witnesses. It is not as simple as, “There is or there is not enough money in the system.” It is also about choices that local authorities are making.

Q551 Rosie Cooper: Absolutely. For example, Lancashire county council only treats and helps very critical need. It has increased charges to such an extent that most people fall off the table anyway. Do you as Minister think that is okay?

Paul Burstow: Well, we have a framework through the fair access to care initiative. The revised version of that was published in 2010 and provides a framework for framing charging policies. Some local authorities—not all—are looking again at their charging policies. They have to do that in the context of the current legislative framework, and in certain circumstances they are, and have been, challenged on process in the courts. Am I satisfied with that? I am concerned that local authorities take the opportunity to engage with service users and carers in an open dialogue about how they redesign services. Where they do that, they are getting better results.

Chair: One more, Rosie.

Rosie Cooper: I just wanted to quickly say, I hear it. It’s all words; it’s motherhood and apple pie. Of course we should be consulting and communicating, but we also have to deliver. Talking isn’t action.

Q552 Chair: Can I just be clear, Minister, about precisely what the Government are saying about unmet need? Are they saying that they do not believe there is unmet need, or do they acknowledge some unmet need, but that is the result of variable performances by local authorities?

Paul Burstow: The first thing to say about unmet need is that defining and measuring it is a hard thing to do. The second thing we acknowledge is that as part of some of the questions we are grappling with from the point of view of a White Paper and funding reform, those changes necessarily require this territory to be explored. Some of your conclusions will be very relevant to that. It is also clear, partly from what I have seen already from the witnesses and from talking to academics, that trying to get a definition of unmet need that works is very hard. Coming up with the figure of 900,000 from the King’s Fund that was cited earlier, which I think is some years old, is open to a lot of academic criticism and not necessarily as robust as we would like.
Q553 Chair: But not being able to measure it precisely is not the same thing as saying that it does not exist.

Paul Burstow: One of the reasons that we recognised the need for a transfer of resources from the NHS to social care was the recognition that putting in resources to fill the gap, alongside efficiency savings, was an essential element because unmet need in one part of the system can drive costs in another part. That recognition was very much part of the spending review judgment that we made.

Chair: A quick one, Barbara, and then Andrew wants to move on.

Q554 Barbara Keeley: Minister, you have talked about consultation. If you are struggling with the definition of unmet need, I suggest—and I think this is very important because I don’t see how you can plan future funding of social care unless you grapple with it—that you talk to organisations such as Age UK and to carers. The people who are meeting the gap are carers who are taking on the load of demographic change and cuts to local authorities. In particular, we should talk to Age UK and carers in those local authority areas where there have been cuts, as my colleague was saying. If you are living in a local authority area where they are dealing with or trying to meet only critical needs, the carers and organisations that support older and frail people will know the definition of unmet need. I think, and I am sure the Committee shares this feeling, that we cannot keep ducking the issue of unmet need. As numbers approach 1 million, it is a serious thing.

Paul Burstow: I do not accept that we have ducked the issue; I am merely saying that measuring it is a difficult thing to do. As part of the judgment that we made in the spending review, we looked at the impact of unmet need in social care on the NHS, and it is an important judgment in the overall funding settlement that we made in the spending review. Of course we talked to Age UK, but I think it, candidly, would acknowledge that it does not have an absolute handle on that unmet need. When you go round, I hope that you do not just go to the places that are saying, “It’s all terrible.” I hope that you also talk to those places that are engaging in the way that I have described and, as a result, are redesigning services and getting better results. They are not just talking about it, but doing it as well.

Chair: We will come to some of that later, but Andrew first.

Q555 Andrew George: In a recent video on the departmental website, you described the fact that care is not free as a “nasty little secret.” I agree that it is probably a shock and is rather nasty for people; I am not sure that it is a secret. Some other aspects are rather nasty and, perhaps, a surprise to people. I will cover three: consistency of assessments, portability and the role of care workers.

On the first point, under the existing guidance of fair access to care services, there is an assumption—I want to probe you on this—that there is a precise science of assessing care needs. To what extent do you believe that that is true? To what extent can you work towards national consistency across all local authorities and achieve consistency in assessing what is either critical or substantial need?

Paul Burstow: There are a number of aspects to that. First, in terms of the recommendations that we have had from Andrew Dilnot and the Law Commission, and that have come out of our “Caring for our future” engagement, there is a bigger question about the nature of the assessment process. The current process is generally described as a deficit model of assessing—it is, “What can’t you do? We will fill that gap,” rather than, “What is it that you can do? What are the assets in your community? What support do you have from your family and wider network of support?” We can reinforce support so that mutual aid and self-care is underpinned. That is one of the challenges of moving from a system that looks back to the 1940s and the poor law principles to a system that is based on 21st century values and is particularly focused on how we get the right outcomes for people. One of the interesting things from the Law Commission’s report is that it says that we need to have a clear set of principles for decision makers. It says that legislation must be founded on the idea of well-being and that it should not only be about providing bundles of services to people, but be about working through with the people, as part of their assessments, the outcomes that they are trying to achieve in their lives. In that sense, it is not a science, because it is about designing bespoke support and outcomes for an individual.

Q556 Andrew George: You are moving the debate in an entirely different direction—to those in need of care being treated either as individuals or in the context of the community, and the support that they currently have whether or not the local authority provides any additional support. I want to get back to whether you genuinely believe that there was ever any chance of local authorities achieving consistency in assessment—quite apart from consistency in services. Would we ever achieve that, or is it a pretense even to believe or imply that it can exist?

Paul Burstow: The Law Commission and the Dilnot Commission recommended going for a more consistent eligibility. The financial services sector, for example, says that that would be an aid to them in terms of coming in and providing more financial services. If we accepted those recommendations, the work of implementation, post-legislation, would be critical in designing the new eligibility framework, so that it could be robustly implemented across the country. In the end, because we are designing a system that is ultimately about trying to achieve the goal of personalisation—of shaping services round individual citizens and enabling them to have lives in their communities—inevitably, I suspect, there will continue to be that sort of tension. It is not a social security yes or no; it is a more complex picture.

Q557 Andrew George: Moving on to portability, we can perhaps assume from your answer that it will be impossible, and might even contradict the desire of a Government, to devolve responsibility and that some issues are matters for local determination in any case.
and should not be part of a Stalinist central control-based system, anyway. Given the portability of those with care needs as they move from one local authority to another, do you agree that it is reasonable that, where hard-won care packages have been agreed and assessments made for a vulnerable person, they should have some certainty, on arriving in a new local authority area, that that package of care within the law is portable and lasts for a reasonable period before they are reassessed later?

**Paul Burstow:** Yes.

Q558 Andrew George: How long should that reasonable period be?  

**Paul Burstow:** In “A vision for adult social care”, which we published in 2010, we set out that we were minded to accept recommendations on portability. There is work to be done on the design of that and, obviously, we want to see your recommendations as well, as we formulate the final version of the White Paper. But we are clear that portability is emblematic of the poor law principles that still infuse our 1940s-designed social care system; that is a classic marker of a system that effectively allowed a state institution to decide who could move and who could not. That has to be unacceptable in a modern 21st century social care system.

We want people to be able to move to where they want to be—to be able to work and be with family or whatever else—so portability is certainly an important part of what we want to see in the White Paper.

Q559 Andrew George: Finally, the biggest and perhaps most nasty secret of all in the care sector is that—would you not agree?—it is built on the backs perhaps most nasty secret of all in the care sector of the lowest-paid. Care workers have had an appallingly unfair press. Of course, where care standards are unacceptably low they need to be dealt with. But we are talking about people on minimum wage working antisocial hours, taking on care levels with. But we are talking about people on minimum standards are unacceptably low they need to be dealt with appallingly unfair press. Of course, where care workers have had an 1940s-designed social care system; that is a classic marker of a system that effectively allowed a state institution to decide who could move and who could not. That has to be unacceptable in a modern 21st century social care system.

We want people to be able to move to where they want to be—to be able to work and be with family or whatever else—so portability is certainly an important part of what we want to see in the White Paper.

Q560 Andrew George: I would be very interested in looking at the methodology, and certainly many of the people I talk to who work in the care sector want to do a good job and are committed to what they do. They feel proud of the work that they do, but in many circumstances they are paid the minimum wage, and have to work shifts—night shifts, and weekend shifts when they would like a social life, but that is denied them. They are doing work which, frankly, I think no one in this room would do for the salary that they get. I question the basis on which those assumptions are made, although I am not saying that those issues are not important.

**Paul Burstow:** May I speak to that point? I don’t disagree with some of the issues that you listed as being reasons why not everyone chooses this as a profession to go into, and of course we need to do a lot more in terms of the work force to raise its status. That is part of the work that we have been engaging in with the sector over the last few months, and it will certainly feature in the White Paper. But in terms of the work that has been done, I was referring to the national minimum data sets that were published in September last year. When care workers were asked what they liked about their role, 31% said they enjoyed the work, 20% said they enjoyed working with elderly people and clients, 18% said they enjoyed improving people’s quality of life, 14% referred to job satisfaction, and only 4% quoted good pay. In terms of why they leave the job, apart from 0.5% who apparently leave because of death, according to the statistics, transfer to another employer is the biggest single main reason. Pay comes in at 4%. I will happily provide those figures, and you can look at the methodology, but that is where I’m getting my evidence.

Q561 Andrew George: If that is the basis of your evidence, it sounds to me as if your Department may become complacent about the fact that you believe that you can rely on the current work force and that they will always be there and be content to be paid the rate they are, and to receive the sort of public press that it seems your Department is almost colluding in in terms of the comments that are being made about the quality of their work.

**Paul Burstow:** That is a bit of a mischaracterisation of the Department’s position.
Q562 Andrew George: I exaggerate to make my point.
Paul Burstow: It is a huge mischaracterisation. I outlined a number of things the Department is doing. Let me mention another one. When the Prime Minister made his announcement, which was reported as being primarily about nursing, he also announced the establishment of a nursing care quality forum, made up of not the great and the good but front-line staff, to advise on how we spread best practice, and to make sure there is a very clear focus not just on NHS quality of care, but on the social care sector as well. One of the streams of work that we were working on with the sector during the autumn last year was around quality and work force. We see those as being absolutely interconnected, and we have had some very good feedback from that. The information is on the Department of Health’s website, and indeed led to some of the coverage in the Telegraph yesterday and the Express today. It seems that the easiest way to hide something is often to publish it on the DH website.

Chair: In addition to talking about those issues, the Prime Minister has also been talking about integration, which I would like to move on to if I may.

Q563 Rosie Cooper: Minister, the Prime Minister is reported to have said that health and social care must be merged. I wonder whether you agree, and if you do, whether you have any thoughts on how, the time scale, and what we are to understand you mean by the words “integration” and “merger”, and exactly who you see being involved.

Paul Burstow: I certainly agree with the Prime Minister that we need greater integration between health and social care, and indeed that needs to reach beyond health and social care into housing and other aspects of public services. What the Prime Minister has definitely not said, if you read The Guardian article that has that headline attached to it, is that there is to be a sort of new grand design of a structural merger of health and social care.

Indeed, the reform programme that we are going through at the moment with regard to the NHS puts in place a number of pieces of architecture that are very much designed to incentivise and drive integration across the system: the establishment of health and wellbeing boards with their specific duties around integration and their responsibilities for looking at the use of the NHS flexibilities around pooled budgets and so on; the duties that are to be placed upon the NHS commissioning groups to integrate services both within the NHS, which is not itself as integrated as we need it to be, and with other providers as well; and the role that the National Institute for Health and Clinical Excellence will have in setting quality standards across health and social care. All these things and others around tariff design and so on are all about one common purpose, which is how we incentivise a system to behave differently and act in a way that ensures services are wrapped or designed around individuals and their needs.

Q564 Rosie Cooper: So you are not really talking about integration; you are talking about voluntary collaboration. Integration is a misnomer in your description.

Paul Burstow: We are obviously on a spectrum of what we mean by integration.

Q565 Rosie Cooper: I have been trying to establish what you mean by integration.

Paul Burstow: What I have just described is a series of steps that are about integrating services. What we know from the research evidence that exists so far, from the advice we have just received from the NHS Future Forum and from the work that the King’s Fund and the Nuffield Trust have done is that this is as much about cultural behaviour as it is about structures. What we are trying to design is a set of structures that reinforce the cultures that we need to get organisations to work differently and to work together. If that means it is voluntary collaboration—I don’t think it is. It is more than just voluntary collaboration. It is definitely sending a very clear signal into the system. I will end, if I may, with one final point. One of the other things that the NHS reform legislation provides for, is, for the first time, a clear statement of the Government’s mandate for the NHS, which has itself to be consulted on, and that is itself an opportunity to make very clear this Government priority, which is integration of health and social care.

Q566 Rosie Cooper: I am still, frankly, bemused by your definition of integration. I still do not actually understand. Again, I go back to being a member of the public—would my dad understand what you have just said? Would I get very clearly what difference it would make to me? The answer is “No, not really.” I will come to actual budgets in a second. I cannot see the model that you are trying to describe. Are you saying that local government and health will be in it? Does that include GPs? How do you get those bodies all working together in what I would call a real integrated system?

Paul Burstow: Let me try again, because obviously I would want to make sure that your dad and others understand what we are trying to achieve here. The key point here is the principle that you orientate the services around the individual and that the services work together to meet a set of identified needs. So that is partly about what we have already been talking about, which is the role of assessment and how you make sure that assessments are joined up themselves, that they do not repeatedly ask the same questions and that different agencies come together.

Let me give you a practical example. Two weeks ago I was in Cornwall, and then I spent some time in other parts of the south-west and I visited Taunton in Somerset. In that situation I was visiting a service that has been established. It is called the integrated support service. Why was it integrated? It was integrated in their terms because it brought together pharmacists, occupational therapists, nurses and social workers. That team had as its remit both prevention of admissions by early intervention and support, and the promotion of safe and effective discharges from hospital in a timely fashion. It provided a combination of emotional support and practical support in terms of speeding up access to aids and adaptations and...
looking at medication reviews once they came out of hospital. It is a combination of things, which, if done well, can enable somebody to get back on their feet and back into the community at the earliest opportunity.

Q567 Grahame M. Morris: May I follow on from Rosie’s question while we are on this subject? The Health Committee did not go to Stockholm or Singapore, but we did go to Carlisle and Preston and saw some excellent examples of innovative, integrated models of co-operation between health and social care. One of the questions I wanted to ask is about an unintended consequence of the Health and Social Care Bill. I am making this suggestion to you, because it has been suggested to us that as a consequence of the changes the Government are bringing forward is that we are disintegrating innovative models of integrated care, and I am sure that was never the intention. How do you respond to that?

Paul Burstow: Thank you. No, that most certainly is not the intention. Where people on the ground are saying that to us, we are working very closely with them to ensure that integrated services, where they have been commissioned, are protected. Indeed, in the NHS operating framework for 2012–13, we have made it very clear that we want to make sure that as we transition from the current system to the new, we are safeguarding and securing existing integrated arrangements. So you are absolutely right. We both understand the concern that there could be an unintended consequence and we are guarding against it.

Q568 Grahame M. Morris: What, in practical terms, can you do to safeguard these new and innovative integrated care models that have been developed? For example, we have had letters from Sir Bill Taylor and the Cumbria and Lancashire chairs pointing out that the Government are imposing governance models in this transitional period as the PCTs are clustering. That is causing their model to disintegrate. I hear your rhetoric, but it does not seem to square with what we have seen on the ground and the evidence that we have.

Paul Burstow: Let me give you the very clear practice?

Q569 Grahame M. Morris: But what, in practical terms, are you doing to support examples of good practice?

Paul Burstow: Let me give you the very clear practical thing we are doing: that is, through the very clear instructions we have given in the NHS operating framework for 2012–13 and the performance management that sits around that as we manage the transition. That is a very practical, real thing that galvanises how the NHS behaves. Of course, one of the other things that is emerging from the move to clinical commissioning groups is that in terms of relationships at a local level, which are a key element in sustaining integrated services commissioning for populations, the fact that you have GPs who are very much part of their population—they get place, they get their geography, as well as their patients—they are often a much more fixed point, just as local authorities are, than the teams of managers within PCTs that move around the country. If anything, we will have a more stable system, which is more able to design and sustain these sorts of changes in the future.
Q571 Dr Wollaston: Right, okay. Coming on to another point, looking at the drivers for this, do you anticipate there is a role for outcomes frameworks in driving this? Is there a case for having a single outcomes framework covering older people, which looks not just at health, well-being and social care, but at housing, and sees it as a whole-system approach?

Paul Burstow: I certainly agree that we need a whole-system approach and we have accepted the recommendations the NHS Futures Forum made to us about aligning the outcomes frameworks for social care, public health and the NHS. When you come to grapple with how you boil those down into one document without making it more confusing, we concluded that having three that do overlap, for example in terms of mental health and frailty is the best way to incentivise different parts of the system to work collaboratively, where working together is an essential part of achieving their own outcomes and assisting others to achieve theirs.

Q572 Dr Wollaston: Right; so you are not going to have a single one.

Paul Burstow: We won’t have a single one because we think there are still discrete elements of social care, and the model that is there as part of social care, that are different from the health service. Having them separate but overlapping is the best way to do that.

Q573 Dr Wollaston: Have you seen the response from Chris Ham of the King’s Fund to your response to the Futures Forum’s report? He has made the point that you need to commit to more specific actions to drive integration.

Paul Burstow: In terms of those iterations, I don’t think I have seen the response to the response of the response. We have written back to Chris and his team in response to their report, and we have agreed that we need to do more work with the King’s Fund and the Nuffield Trust on how we take forward their recommendations and those of the NHS Futures Forum. They are absolutely right: there is a lot of work going on, for example, with regard to health and well-being boards. There is a whole early-implemented programme that is not particularly visible, unless you are involved in it. That is bringing together directors of public health, GPs and local authorities. They are working through a whole series of learning sets, and again we can send you some details on that. That is proving quite galvanising across the system in terms of getting people to talk differently about how they integrate these services.

Yes, we are going to continue working through the recommendations and ensuring that they are reflected in the White Paper we will publish this spring, in terms of what next steps we need to take. The last thing I would say, picking up on your earlier question, which I forgot to mention, is that Monitor will also have duties around integration. The duty on Monitor is to promote the interests of patients, and it can use as its tool for doing that, integration, just as much as it can choose competition. The key thing is that it needs to do it in the interests of the patient.

Q574 Dr Wollaston: If it starts implementing it in a way that is not driving integration, will you have powers to step in and direct it to behave differently?

Paul Burstow: Not in the sense that you mean. In listening to colleagues in the Lords, we are looking closely at the way in which the NHS mandate’s writ would run across the system. That is an issue which I think will be explored further on Report.

Q575 Valerie Vaz: I want to take you back to a couple of points. Obviously, colleagues have covered various things, but I just want to clarify a few things. You mentioned Torbay. Have you actually visited Torbay?

Paul Burstow: Yes.

Q576 Valerie Vaz: When did you do that?

Paul Burstow: I think it was last summer.

Q577 Valerie Vaz: Do you see a future for the care trusts?

Paul Burstow: I think that they proved to be an interesting experiment, but as an experiment they did not really get out of the lab. One of the problems with the care trust model is that it did not lead to any significant transformation across the service. I think they can teach us lessons about how you can orientate organisations around people. The interesting thing about visiting Torbay was their model of saying, “How do we get this organisation to change the way it works? We have to think about Mrs Smith.” That is their sort of way of mobilising that. It was not just the structure; it was about the culture and behaviours within the organisation. Those are the lessons I take away from my visit to Torbay.

Q578 Valerie Vaz: So you saw a model that actually worked, did you?

Paul Burstow: I saw a philosophy that had been translated into a set of operational responses, but the philosophy—

Q579 Valerie Vaz: That worked?

Paul Burstow: Yes, it did—not the structure, but the philosophy.

Q580 Valerie Vaz: We visited yesterday, and what we heard were public servants who thought outside the box and thought about their patients, their clients and their customers. I hate using that word “customers”, because I do not think they are customers in such circumstances. They went beyond what they were asked to do, as public servants, and developed a system. You have accepted that that works. There is an element of good practice. Could that not be looked at and rolled out throughout the country?

Paul Burstow: There has also been a research programme around integrated models of care, which published in the autumn of last year. I think it pointed us to not simply seeing structural changes as the key component in delivering different behaviours among staff and the organisations that commission those staff. That is why the health and well-being board programme is now as much about changing cultures
and behaviours and supporting different behaviours. It is also why, as I say, when I visited Knowsley—because I have visited Knowsley—and when I visited Torbay, the interesting thing was the organisation’s philosophy, which they then translated into the way they ran themselves: it was fundamentally about centring themselves around people, what needs those people had and how best to meet them. I think that is a very good philosophy.

Q581 Valerie Vaz: My point is that it works in an area. I am just thinking of saving the public money. Taxpayers’ money is very important and a lot of costs have been incurred with the reforms. I am just saying that a model works. Why can you not use that to translate it into other areas? I will come on to the health and well-being boards, but is that not a model that you could perhaps continue to pilot?

Paul Burstow: Clearly, that is an issue in terms of policy formulation that, if the Committee wants to make recommendations on it, we would need to consider in the context of a response to the White Paper and of a response to your recommendations.

What I am saying is that, for one reason or another, before this Administration took office the care trust experiment never escaped the lab. The last Government never actually got round to doing whatever would be necessary in their terms to direct it to happen. We are now taking a different approach—health and well-being boards are a key part of that—to drive integration not just in a few places, which is all that was ever really delivered with that programme, but across the whole of England.

Q582 Valerie Vaz: One of the things that we picked up from that was the flexibility they had, when people are coming out of hospital, to look at extra care and homes that people can go to—they can buy a few beds—so you can have that halfway house and you are not clogging up beds in a hospital. One of the things that strikes me about this general debate is that we see the elderly as a kind of problem. We need to kick them out of their homes. We need to get them to pay for the care that they have actually paid for already through their taxes, if they have worked. That brings me on to the housing issue. That is something that came across in evidence. Do you not see a role for housing associations or people involved in housing, in relation to the elderly, on health and well-being boards?

Paul Burstow: You are absolutely right that housing is a key component in all of this. That is why in the guidance we will be publishing about joint strategic needs assessments there will be very clear guidance around the need to build into that housing needs assessments. There are very clear duties already on local authorities. My colleagues in the Department for Communities and Local Government recently published a strategy. There have been more announcements today about housing. I agree with you that we should not be having some sense of consternation about the fact that we have been successful as a nation in enabling people to live for longer. We should be focused on how we compress morbidity, how we actually ensure that people live well, for longer and less disabled as well?

Q583 Valerie Vaz: Generally, in terms of all this joined-up thinking, do you have any systems in place for a national strategy to look at housing, welfare, health and social care? Are there any systems in place this year?

Paul Burstow: It is called the White Paper, and we will be publishing it this spring.

Q584 Valerie Vaz: That is now? Do you have any systems in place?

Paul Burstow: In terms of cross-Government—

Q585 Valerie Vaz: You do not have to be sarcastic with me. I am aware of a Government White Paper.

Paul Burstow: I apologise. But it is. That is the place where—

Q586 Valerie Vaz: But do you have any strategies in place?

Paul Burstow: If I came across like that, I apologise.

Q587 Valerie Vaz: Yes, you did.

Paul Burstow: The White Paper is very much that document. That is the place that pools together a lot of work that has been going on in the Department since the Government came into office. Yes, it will look across the Government as well, so we are obviously with colleagues in other Government Departments as part of the formulation and finalisation of the White Paper. Of course, there are those inter-ministerial discussions about housing and other matters.

Q588 Valerie Vaz: Is the Department currently developing other models in terms of flexible housing? We have a situation where we have deferred payments already, and an elderly person’s house stands empty while they are in residential homes. What is the Department’s thinking on flexible housing?

Paul Burstow: Some of this has actually come out specifically today. Grant Shapps from CLG has made some further announcements.

Q589 Valerie Vaz: Well, Grant Shapps is not here, and you are.

Paul Burstow: I am trying to demonstrate the fact that the Government are joined up and what we are doing on housing, which is not directly within the Department of Health’s responsibility. But in our work on social care reform, we recognise—

Q590 Valerie Vaz: That it is coming out, yes.

Paul Burstow: In that context, one of the things that Grant Shapps has announced today is building on a programme for the London borough of Redbridge where they have been looking at how they can support people to downsize—not force them to downsize, but support them to make that choice. We know from the International Longevity Centre, for example, that people underestimate the scale of what they will need to do to future proof their homes. All of those are
things we are factoring into the work that we are doing, leading up to the White Paper and its implementation.

**Q591 Valerie Vaz:** But you definitely do not see a role for housing specialists on the health and well-being board, or are you open?

**Paul Burstow:** Not as a mandatory thing. We have a small number of core members.

**Q592 Valerie Vaz:** Could they sit at the table?

**Paul Burstow:** But the interesting thing, of course, is that many directors of adult social services—obviously not in two-tier areas—are, in fact, double hatted. They have housing as another of their responsibilities, so the housing conversation is very much part of the role of the health and well-being boards.

**Q593 Valerie Vaz:** In terms of following the money, could the money go through the health and well-being boards or do you see it going to the CCGs?

**Paul Burstow:** The money for social care from the NHS?

**Q594 Valerie Vaz:** Yes.

**Paul Burstow:** The money for that very clearly goes to the local authority to support their social care activities. Health and well-being boards are legally part of local authorities, and it is the most logical place for those conversations to take place.

**Q595 Chris Skidmore:** You said that it was more ethos than structural form that had driven change, but where we went to visit yesterday it was very evident that pooled budgets were necessary in order to drive the change needed in Torbay and so reduce hospital beds. The long-term savings that were made in the NHS were the result of almost the NHS pump-priming social care. I am interested whether you would rule out any future decisions about whether we should have pooled budgets across authorities or clinical commissioning groups? Or is that something that you do not believe is effective?

**Paul Burstow:** The danger of mandating such things is that you wind up getting perverse behaviours because people have been told to do it rather than actually seeing the logical case for doing it. That is why the ethos issue is very important. I am not today ruling it out. I would be very interested to see what your Committee’s recommendations are on this. We will be saying more in the White Paper about integration and further incentives.

**Q596 Chris Skidmore:** If you look at integration as a permeation between those budgets, you would possibly be thinking about allowing local authorities and local NHS organisations the freedom of decision to pool budgets.

**Paul Burstow:** One of the other ways in which we think this can be driven and an area where we are determined to move at pace is the whole area around personalisation and, within personalisation, the use of personal budgets. We have made a very clear commitment about rolling out personal health budgets, particularly in regard to continuing health care, and we are progressing at a good pace now in terms of personal budgets within social care. We want to be able to see people, when they choose to have those personal budgets, in a position to bring those budgets together to achieve the outcomes they need.

**Q597 Chris Skidmore:** Are personal budgets the only mechanism that you would be happy with? Obviously, the whole roll-out of personal budgets is gathering pace. It will deliver results, but would you then, once that has happened in the course of this Parliament, look again at maybe—

**Paul Burstow:** We of course will keep looking at these things. I do not see personalisation and personal budgets as the only way. I think they are a very powerful way of allowing people to take control of things and shape the services they need, both health and social care and, through Supporting People, housing. That is about meeting their needs. But I also think that the work that health and well-being boards will do in terms of assessing the population needs together across health and social care, building in the housing input I was talking about and then framing the commissioning strategy for their population is a game changer in terms of the way in which organisations are going to work at local level and the way in which the personalities within those organisations collaborate.

**Q598 David Tredinnick:** I am hoping to ask you a few questions about personal budgets later in the proceedings, but for the moment can we just go back to health and well-being boards and the fact that the Government rejected a recommendation of the first Future Forum report? I just wondered why. This was the recommendation that “Health and wellbeing boards should agree commissioning consortia commissioning plans which should be developed in line with the joint health and wellbeing strategy.” Can you explain why the Government rejected that, please?

**Paul Burstow:** Yes. Basically, we see health and well-being boards as being a pooling of sovereignties between two agencies that have very different accountability frameworks—between local authorities and the NHS. The NHS has clear accountabilities ultimately to Parliament. Local authorities clearly have accountabilities directly to their electorates; they are elected bodies. Effectively to hand to local authorities an absolute veto over commissioning decisions by the NHS would have blurred those accountabilities. It would have been a de facto transfer of responsibility and accountability to local government. That was not what the Government wanted to do, and that is why we have taken the view that we do need to see joint strategic needs assessments and health and well-being strategies as a part of the continuous process of commissioning. They are not separate; they are part of the cycle of planning services. That places local authorities in a very different relationship, but not one of being above the NHS or subordinate to it.

**Q599 David Tredinnick:** I am not sure I see where this absolute veto comes in. The recommendation was
that “Health and wellbeing boards should agree commissioning consortia commissioning plans”—that there should be some link with these fledgling commissioning consortia. It seems a bit strident to say that we do not want to get involved in absolute vetoes. Surely what we are talking about here is sensible communication to achieve joint aims, which is quite different.

Paul Burstow: Absolutely, and that is exactly where the position of the policy is now, in that what we are saying—

Q600 David Tredinnick: If that is the case, surely you have rejected just what you have agreed to.

Paul Burstow: No, no. What we rejected was the notion that there would be a sign-off by a health and well-being board. What we have accepted is that you have an iterative process, an ongoing process, of reviewing and examining the commissioning plan that has been produced by the CCG. The CCG doesn’t just take the health and well-being strategy, go away into a dark room, produce its commissioning plan and then hand it back and say, “Do you like it or not?” That is a sort of sign-off process. It is actually one that it is collaborating with throughout the process of producing the commissioning plan. It is absolutely the case that what you have described is what we intend to be the way in which these relationships and processes work.

Q601 Rosie Cooper: So it is a talking shop.

Paul Burstow: No, it is not, because the idea of agreeing and determining population need, translating that into the priorities for commissioning—they are most certainly not, because they have themselves legal force, which commissioners will have to take into account and demonstrate that they have taken into account. That is both social care commissioners and health commissioners.

Q602 Chair: Can I just conclude this part of the discussion by taking you right back to the beginning, Minister? You said that The Guardian had got it wrong when it reported that the Prime Minister had told the Health Secretary, Andrew Lansley, to formally merge the two areas—health and social care—“to save money” and improve patient care. That was a wrong report was it?

Paul Burstow: I have to be very careful because I said some things a couple of years ago that really upset The Guardian. I apologised to it at that time, and I do not want to have to apologise again. What I said was that if you look at the headline and then read the first paragraph and the rest of the article, the article does not really bear the headline that the sub-editor put to the story. The story is principally about the report of the King’s Fund and the Nuffield Trust. There is not actually any direct attribution to the Prime Minister at all.

Q603 Chair: But if it is wrong that the Prime Minister has told the Health Secretary to merge the two departments—and I can understand that that might be wrong—what the Committee is hunting for is the sense that there is a game changer here. Forgive me for saying so, but I have given evidence to Select Committees in the past when I have held briefs similar to those that you hold and I have described the importance of co-operation between health and social care. Indeed, my predecessors in ministerial roles have done so even further back into history. We are hunting for why things should be different in the future? What is the game changer? Or do you think that this needs to be a continuous development and there is nothing more urgent about this now than there was in the past?

Paul Burstow: The point that was made very strongly to us after the Future Forum’s work is that there is not a silver bullet. There is not one thing that will change the system and make all of this happen, which is what you are hoping we can offer. But what it does say is that a whole series of things can incentivise and drive organisations to work differently. You are right: it is a process and an endeavour.

What we have put in place, once the legislation that is currently before the House of Lords secures Royal Assent, is a whole series of new nudges, pressures and obligations in the system that force the system to behave differently. If you are looking for the nearest thing to a game changer, it is the issue of personal budgets and the personalisation agenda—the ability to hold a personal budget that sits across your health needs, your care needs, your housing needs and, through the trailblazers the DWP are leading, perhaps some elements of benefits as well. That allows you to start personally integrating services to meet the needs that you have in a way that best fits your circumstances.

Q604 Chair: But if you are going to deliver the objective of much faster rated integration—I accept that it is a process not an event—personal budgets are part of that. If you want to create structures that allow commissioners to look across institutional boundaries, you need to give them incentives to do so. I do not understand how you deliver integration unless those incentives on commissioners exist.

Paul Burstow: I would say that the health and well-being boards are the place where those boundaries disappear. The processes I have described already are part of that.

Q605 Chair: But do those boundaries disappear if the health and well-being board is still responsible for different budgets and, as you stressed, different accountability systems?

Paul Burstow: One of the very specific things that health and well-being boards are obliged to do is to ask themselves the question: should we be using the NHS flexibilities to allow us to commission services differently?

Q606 Chair: When you say NHS flexibilities, you mean section 75.

Paul Burstow: Yes, precisely. It is not an afterthought; it is a forethought. It is part of the process right from the outset. In other words, why would we not want to use these where we commission differently and better for our population?
Q607 Rosie Cooper: But the health and well-being board does not commission. The problem here is that there is no connect. It has no power. You keep on saying that the health and well-being board will commission. It can make suggestions and can agree, but it does not actually do.

Paul Burstow: And of course it is possible, under the flexibilities, for CCGs to delegate some of their commissioning function, so that it can be exercised through health and well-being boards. What you say is not strictly true.

Q608 Dr Wollaston: Every part of the country obviously is different and a model that applies in an inner-city would not apply in a rural area. Do you take a view on being parts of the country where there are really outstanding examples of integrated health and social care delivering real results for patients? If so, why are you not rolling those out and saying, “These are the models that people should be adopting?”

Paul Burstow: There are lots of places that are, as you say, delivering truly excellent services and are genuinely integrated. I mentioned the example in Taunton; that is just one. I also visited a service in Bristol, which is integrating around intermediate care. Our dilemma in looking at the experience of rolling things out is how successful that end practice has been in the past. Although we are directing some programmes from the centre, we do not think that you can achieve the best outcomes for individuals through dictating a fixed model of integration and saying, “That’s what everyone should do.” We think that health and well-being boards are the places where these issues are worked through, where the relationships that are essential to good commissioning across service boundaries are debated and decided and where the priorities are set.

Q609 Dr Wollaston: So you see the health and well-being boards as the guiding mind that will, in each area, dictate the model that is right for it.

Paul Burstow: I would describe them as the local system leader. They are not just a talking shop; they are the key place in driving reform across the system.

Q610 Chair: Including the whole national health service budget: the acute sector as well as the more obvious local authority sector.

Paul Burstow: Absolutely, because in the end the building blocks are there: the joint strategic needs assessments and the health strategy are set within the context of the board.

Q611 Dr Poulter: I am sure that we will turn to Dilnot in a moment, but funding is not necessarily the main issue. We should be talking about the real issue, which is the way that the system is configured in terms of social care and whether there is co-operation, or lack of it, between different players in the field—the NHS and social care. Is not the system broken? The issue of funding is secondary to that.

Paul Burstow: I accept that the system of social care that we are currently operating—the model of care is fundamentally a crisis-management model—is broken. We need a system that is promoting well-being, focused on early intervention and providing advice, guidance and navigation through the system. Those are key elements in any reform that we need to put in place.

One thing that has come across time and again during the engagements that we have had is that, if we are looking for game change, it is a not a single thing. But taking the recommendations of the Law Commission and enacting them would provide a fundamental shift in the way that the system operates, moving from services to outcomes, from crisis to well-being, and so on. So it is an important change.

Q612 Dr Poulter: Sure, but in respect of an issue and concern that has been raised so far, yes, you are right: it is a crisis-management model. The problem is the financial drivers of the model—for example, with regard to payment by results in hospital care, where a hospital is only rewarded for acute care in that hospital and is not rewarded for preventing admissions and working collaboratively with community care or for working to look after the patient when they are discharged from hospital after they have broken their hip, because there is fragmentation of the payments system. Unless we get the payments system and tariff system right—look at chronic disease tariffs and that sort of thing—we are never going to get the drivers of care right.

Paul Burstow: I would certainly agree with that. Obviously, we have inherited a process of tariff design that has been very focused on episodic care and acute care. What we announced in the White Paper for reform of the NHS 18 months ago was the beginnings of design of new year-of-care tariffs in mental health, for children’s mental health and for long-term conditions.

I confirmed just before Christmas that we are now working to put in place the first tariffs around long-term conditions, for the very reason that you described. We want the patient pathway to be properly funded. That does mean investment outside of the acute sector. It is certainly a key part of how we incentivise those sorts of changes.

Q613 Dr Poulter: Sure. There is an acceptance that we need to look at some chronic disease tariffs, so thank you—that is very useful. The NHS will be much better at managing people with long-term conditions through chronic disease tariffs, but actually the question of how we tie in and bring in social care to that mix is a bit more complex. We have some good examples, which have been outlined by you and members of the Committee, where social care is very well integrated with NHS care, but actually that is hugely variable and relies on the good will of the staff and of different organisations working together. As we have seen, and as you have conceded, mentioned and agreed with on the NHS model, it is putting in place those financial drivers to drive integration that matters. Is there not a case for the Government to push in a meaningful way for pooled budgets between social care and NHS care to make sure that we break down these cultural silos that have existed for many years?
Paul Burstow: That goes back to Mr Skidmore’s question earlier on. What I have said is that we are not ruling it out for ever. We have a series of things that we are doing that we want to embed around the role of health and well-being boards. Something that came across very strongly during the engagement and that undermines attempts to get the systems to align and to work around the needs of individuals is the leadership in the system. We tend to teach people to be leaders in silos rather than to be leaders across systems. One of things that we are looking to say more about in the White Paper is how we drive change in the way that we are teaching and training and continuously professionally developing leaders across health and social care so that they are able to work across the system to break down those boundaries. That is a very important means of overcoming some of the concerns that you describe.

Q614 Dr Poulter: Sure. That is true, but, to some extent, that happens already. For example, you have it in a hospital. You have multi-disciplinary team meetings. You have occupational therapists working together with physiotherapists, social workers, doctors and nurses. That has been happening for a number of years, yet we still have the problems that we have described—discharge planning and the fact that care in the community does not happen effectively for very many patients when they go home. We see a lot of issues about the frail elderly being readmitted to hospital due to inappropriate admissions, so we know there is a big problem here. The key issue is that unless we get the budgets aligned—we have good will among teams and workers already, working together—is working across the system ever going to happen?

Paul Burstow: There are two things that we are doing that speak to that. Specifically, one is the introduction of a post-discharge 30-day tariff that will effectively provide the bridge from hospital back into the community and a funding stream to support development and investment in services. The second is to pump prime that. During this spending review, we agreed to put in £150 million this year, £300 million from April into re-ablement and a further £300 million the year after. We are trying to address that but in a systems way. There is no point just fixing the bit about discharge. You have to have both ends of the pathway right as well.

Q615 Dr Poulter: That is hugely welcome, but do you think that a 30-day tariff is enough to bring in and tie in social care? I am talking about the long-term social care needs of an older person in particular. The rehabilitation will happen, I am sure, and hopefully be effective for some conditions in 30 days, but effectively tying in social care is about not just a 30-day tariff, but something that is longer term than that. That is where the drive and the emphasis from members of the Committee has come on pooling budgets.

Paul Burstow: Because a lot of the conversation in this Committee today has been about how we manage demand, the gap or whatever, and the pressures on the system, one of the things that is worth saying about all that is that the investment through that new tariff in re-ablement and the investment we are putting into re-ablement itself unlocks resources in social care. There is a huge incentive for social care to come to the table and to be part of designing those services. Indeed, in the operating framework, we made it clear that they must be at the table designing those services. We know that studies have shown that in the 10 months after a re-ablement package has been delivered, social care costs are 60% lower than they otherwise would be, so there is a huge economic compulsion there, let alone anything else.

Q616 Dr Poulter: I absolutely agree that there is a huge compulsion, but the driver is still lacking. I have one final question. Currently—the Dilnot report flags this up very well—the NHS has done pretty well in terms of funding increases under the previous Government, but social care, old people’s funding and social care funding lag somewhat behind. For the future, how would you envisage the distribution of funding between welfare and housing for older people and the NHS? Do you think that is something that needs to be looked at, leaving aside the issues of pooled budgets?

Paul Burstow: Forgive me, but those are very much the sort of questions that get looked at by Governments in spending reviews. We made a judgment about the relative allocation between those areas in the last spending review. If the Committee has thoughts on informing our policy process to write a White Paper, then we would be very keen to see your own phrase, pooled sovereignty, so there is a spending review to look forward to.

Q617 Chair: Do we not have to stop tiptoeing up to this fence and then constantly refusing it? We have heard this morning that section 75 flexibilities allow us to ignore this difference. We have heard that health and well-being boards are going to look across the boundaries. Now we have heard this new excuse—forgive me for saying so—that there is a spending round and we have a set of decisions about how much is on local authorities and how much is on the NHS? Do you think that is something that needs to be looked at, leaving aside the issues of pooled budgets?

Paul Burstow: My argument—the Government’s argument—is that the things we have already done, the things that are in train as a result of the legislative reforms we are making at the moment are no small thing. But they are, taken together, a significant set of changes that drive the system in the direction we both want it to go, which is towards a more integrated
system. If the Committee has things that it thinks we ought to consider further, we have said—I have said today—that the White Paper will consider further issues about how we take forward the recommendations from the NHS Futures Forum on integration and also from the King’s Fund. We will obviously want to respond to the Select Committee. What I am not doing today is adding yet another set of things. We are doing a lot. I would be happy to provide a note setting out the totality of the work that we are doing across the systems to drive integration. I don’t think probably that I have done it justice in all the answers that I have been able to give today.

Q618 Chair: If I may say so it would be very helpful to have a crisp set of why it will be different. It is the strong view of the Committee that it needs to be different. We have yet to be persuaded that it is going to be.

Paul Burstow: I will happily make sure that happens.

Q619 David Tredinnick: This ties into personalisation, which I think we are moving towards. Why are service users prevented from using part of or all their direct payment to purchase care services from a local authority? Doesn’t this build on the Chairman’s point that we are dancing around the issue? My understanding is that service users are prevented from using part of or all their direct payment to purchase care service from a local authority. Isn’t that an artificial hurdle in the current climate of integration?

Paul Burstow: The first thing to say about that is that is a continuity point—it is not something that this Government have just imposed as a new requirement—but it is the case that direct payments are one of the routes by which people can take more control over their care and how they want to see their care organised. Personal budgets are also alongside that. So for those who do not want necessarily to take all the responsibilities of managing the budget and so on, personal budgets provide an alternative. These things sit within an agenda about personalisation that is much richer than just giving people money.

Q620 David Tredinnick: In fairness to you, you said that you want to orientate the services around the individual and talked about allowing citizens to have lives in their communities. Indeed, the Committee—sadly, I was not with them—was in Taunton yesterday, which we have already discussed. One of the points I understand from our earlier discussions that came up was that people are electing to use acupuncture, for example, which is now available through NICE guidelines for lower back pain, as we all know. I would suggest that has considerable cost-saving elements because it is very cost-effective—it is the cost only of the needles rather than drugs. People clearly want those options, so there is a whole range of services in the complementary world that you might want to address, Minister, when it comes to the White Paper you are preparing. There will be a demand for a whole range of other services: homeopaths are out there, the Royal London Hospital for Integrated Medicine, and there is also one in Bristol. Public demand is likely to shift. I respectfully suggest that you might want to include that in your White Paper.

Going back to the point I just made, which has been put to the Committee before, local people want to be able to spend some of that budget on local authority services, and I think that is something that needs to be looked at. We have also heard examples of people being offered personal budgets that will not meet their needs, and are not equivalent to services offered by their local authority. What can you do to reassure people that personal budgets are not being used to ration care?

Paul Burstow: On your point about alternative ways of meeting needs and your example of acupuncture, I could give another example, which I saw when I met the user of a personal health budget who had COPD. They could have been sent in the traditional service model down a physiotherapy route, but they chose instead to use some of that resource to join a choir. The follow-up on their health status showed they were healthier; they had broken down social isolation; they were out in their community. So they got both well-being benefits in terms of their mental health as well as physical benefits of actually using their respiratory system through the choir. That ticked the boxes in terms of health. Being creative with personal health budgets is one of the real opportunities out there, and I agree with your point in that sense.

Q621 David Tredinnick: On the point you have just made, one thing about singing, of course, is that it has a dramatic impact on the body, just going through a range of notes. There are many studies out there. I absolutely agree that if you are going to think out of the box, there are a lot of other ways: music, playing trumpets, as I know from someone I know well.

Valerie Vaz: I am just worried about the headlines: “Scroungers playing the trumpet.”

David Tredinnick: For children with asthma, playing a trumpet or cornet is a very effective way of expanding their lungs and getting rid of the problem. There are many studies that show that. We had better not dwell on that. I am sure the Chairman wants me to stay within the bounds.

Paul Burstow: What I was going on to say was that the opportunity that personal health budgets and personal budgets give is not so much for the state to think outside the box, but to allow individuals to think outside the box. It is that fundamental shift that this is about.

On your point about reassurance on personal budgets and the levels, there have been some figures published recently. My challenge to colleagues in local government is that they should be looking across the piece at the levels that are being set and should use that to challenge. In terms of the longer-term assurance, the change in the legislation that would come from recommendations from the Law Commission will, I think, give the greatest assurance, because it is about saying, “What are the outcomes a person wants to have in terms of meeting their needs? What are the services they need?”, and about providing clarity about what the decision makers in the system have to do. Those things are absent at the
moment because of the very complicated, complex, confusing legal framework that we have.

Q622 David Tredinnick: My last question relates to what you have just said. How do you integrate health and social care funding for individuals who do not qualify for integrated personal budgets?

Paul Burstow: This is someone who may well be entitled to a personal health budget because they qualify by need, but is affected by the means-tested nature of social care, which comes back to Andrew George’s earlier point. The issue of people not knowing that they potentially face catastrophic costs in social care and that it is a means-tested system is one of the nasty secrets of social care. We still see headlines in our newspapers that convey the impression that those who write those headlines do not know themselves that social care is not free and never has been. That is a real problem. Therefore, making sure that we have designed the system in a way that makes it far more transparent is critical to encouraging people to plan and prepare for their future care needs in a way that most people do not. Therefore, making sure that we have designed the system in a way that makes it far more transparent is critical to encouraging people to plan and prepare for their future care needs in a way that most people do not. People make a distress purchase at the moment. To come back to your point about not being able to integrate the budgets, we increasingly need to allow people who are self-funding their social care needs to bring together their commissioning of services and the support they need with their personal health budget. There is no reason why they should not be able to use their own resources, as self-funders, to reinforce and support their overall package of care and support.

Q623 David Tredinnick: In my constituency, people are turning to sport and are electing to get involved in physical activity to reduce stress. Choirs are another way of doing that. I am pleased to hear that you are thinking in a wide-ranging way about many different options, which, I am sure, will offer much support they need with their personal health budget. There is no reason why they should not be able to use their own resources, as self-funders, to reinforce and support their overall package of care and support.

Q624 Barbara Keeley: Can I bring us back to funding? Minister, you have just said that care is not free and never has been. Care would have been free for the 400,000 people in greatest need if the Personal Care at Home Act 2010 had not been stopped and reversed by this Government, so you should not say that. That was an opportunity to give free personal care to some people.

Paul Burstow: That was a future event that did not happen because the election did not produce that outcome.

Q625 Barbara Keeley: It was a piece of legislation that had gone through. On Dilnot and funding, would it be fair if people with the same social care needs reached the Dilnot cap on care costs at different times? To balance that, if you think it would be unfair, should we be looking at a national pricing structure and resource allocation system to make sure that whatever decisions are made about the Dilnot cap, and whatever level it is set at, people reach it at the same time and that there is not a new postcode lottery?

Q626 Barbara Keeley: I see. Can I come back to the issue that I asked you about earlier? I and the Committee need to be absolutely clear about your estimate of the gap between levels of local authority social care funding and levels of need. Perhaps you can tell us again if you do not think that there is a gap. What do you think that figure will be across the next 10 years?

Paul Burstow: If I may, Mr Dorrell, I would like to provide a letter that recaps on things that I have said in public before. Back in 2010, after the announcement of the spending review, I set out to the Association of Directors of Adult Social Services conference exactly how we got to the numbers and how a robust programme of efficiency and improved productivity in social care would mean that there need not be a gap. The current level of service can be maintained, and choices by local authorities are key to whether there is a gap or not.

Q627 Barbara Keeley: But do you believe that there is a gap? You are now saying that there need not be one—is there?

Paul Burstow: I believe—this is turning into a theological thing, and I don’t mean it in that sense—that prior to the spending review settlement, a gap was identified. The spending review settlement, through a combination of additional resources of £7.2 billion in this Parliament and a rigorous efficiency programme, requiring up to 3% efficiency savings a year by local authorities, will be sufficient to allow local authorities to choose to maintain the current level of provision. Some local authorities have chosen to invest more in their services in the past year and a half; others are choosing not to. The overall change on the CLG
figures shows a 1.5% reduction in spend on social care. We know from the ADASS survey that local authorities say that 70p in every pound that they have taken out of spending on social care has been done through transformational change and service redesign.

Q628 Barbara Keeley: The ADASS figure is that £1 billion less is being spent on social care.
Paul Burstow: Of which £700 million comes through service redesign, and the balance from tightening eligibility criteria, changes in charging policies and so on.

Q629 Barbara Keeley: So are you saying there is not a gap? You have said there does not need to be a gap; are you saying there is not a gap?
Paul Burstow: I am saying that, after all that Government can do, there should not be a gap, but then there is a decision that each local authority has to make about how it uses the resources.

Q630 Barbara Keeley: You are not answering my question; is there a gap? Not, “Does there have to be?”
Paul Burstow: I think I am answering the question. I am just not answering the question in the way you would like me to answer it.

Q631 Barbara Keeley: I am asking you a question. You are the Minister responsible for social care services. People say that social care is in crisis. Is there currently a gap between local authority funding and need?
Paul Burstow: I am saying that when we came into office, ahead of the spending review, there was a gap. We took decisions about the amount that central Government could provide to support social care during this Parliament—£7.2 billion. And we identified the need for there to be a rigorous programme of efficiency savings—3% per annum by local authorities. The Association of Directors of Social Services agreed that that was necessary and is taking steps, along with its colleagues in the Local Government Association, to deliver that. It is therefore down to judgments by individual local authorities about their own priorities as to whether they spend the money to secure that outcome or not.

Q632 Barbara Keeley: So you do not see a gap? I think it is a straightforward question.
Paul Burstow: And I think I have given straightforward answers several times.
Chair: We are getting into a Paxman situation.

Q633 Barbara Keeley: My final question was going to be about what proposals the Government had to address the current funding gap. Presumably, as you think there is not a current funding gap, you are not putting forward any proposals.
Paul Burstow: What I said earlier is that we obviously take a view, as we come towards the next spending review, as to what the demographic pressures and cost pressures are in the system, about what the baseline is and what we have to do if there is a gap that needs to be closed. But we did that in the 2010 spending review. We put in place sufficient resources to enable local authorities, if they so choose, to protect social care at its current level.

Q634 Chair: Can I develop the question in a slightly different way? If it is true, following Barbara’s question—I am not seeking to re-ask it—that there is not a gap, why are we considering the Dilnot proposals to raise more money for social care? Is it part of the policy purpose of the consideration of the Dilnot options to unlock new resources for social care?
Paul Burstow: The way in which I see that, and I think the way in which Andrew Dilnot, when he spoke to this Committee, also sees it, is that it is about enabling more private wealth to be levered into the system, so that people can spend more, and earlier, on interventions that actually probably would lead to a reduction in their lifetime care costs, if they do it in a planned way, rather than in a crisis. Dilnot, of itself, was not about leveraging in more state resources. That was not the question in the terms of the reference that we set him. His question was, “How do we get a fair balance between what the state and what the individuals provide?” How do we enable people to insure that risk—not in the literal sense, but in terms of what means, through financial services, might be available? His view, which has been confirmed through our engagement with the financial services sector, is that it does create a space, depending on the level of cap you set, to grow a financial service market that allows the whole character of social care to change from a distress purchase to one where you are planning in advance to mitigate—future proof—your care needs.

Q635 Chair: Is it the Government’s view that it is necessary, in order to maintain a properly funded health and social care system, to unlock those new resources going forward?
Paul Burstow: They are an essential component going forward, because they also speak to another issue that is very important, and which we spent a lot of time in the autumn discussing with the sector, which is about quality, and how we make sure that people can, through greater choice and awareness of what the options are to meet their care needs, also help, through those choices, to drive improvements in quality. That quality will be a very big part of what we will set out in the White Paper.

Q636 Chair: It follows, does it not, that if in the Government’s view it is necessary to address both volume and quality of demand, if the policy conclusions that come out of the Dilnot process raise less money than Dilnot proposed, the funding gap will remain?
Paul Burstow: The fundamental point, which was very strongly put to us during the engagement and which I think is absolutely right, was that we should not accept the inevitability of current demand pressures in the system. We should be looking at how our current models of care can be changed to models of care that bend the demand curve, bend the cost curve, and drive the quality curve up. That is at the heart of what we want to bring forward.
Q637 Chair: But that is a constant isn’t it, whether or not we do Dilnot?
Paul Burstow: Absolutely.

Q638 Chair: The point about the Dilnot process is that it unlocks the opportunity of new resources.
Paul Burstow: It unlocks potential new resources. He would argue—and he did in his report—that it unlocks an important set of nudges and behavioural changes as well.

Q639 Chris Skidmore: I want to go on to the point about financial products, given that it was raised a moment ago by the Minister. We had the ABI here several months ago, voicing general scepticism that if the cap is set at a certain level—say £35,000, as per Dilnot—you wouldn’t really have an appetite within the financial sector to provide those products. Obviously, the industry group has been set up to look at that, and I was wondering whether you are able to describe the process or say what information you have on the latest industry news about how this would work. We have seen in the news, and yesterday in The Daily Telegraph, the idea that the cap might be £60,000, which might be viable for the industry to enter. Andrew Dilnot said to the Committee that he would be reasonably happy if the cap was around £50,000. I understand that you may not want to talk in detail since current cross-party talks are ongoing, but if you are able to provide an update, or any idea of the financial products, I am sure that would be welcome.
Paul Burstow: The report in The Daily Telegraph, and subsequently in the Daily Express today, is an accurate reflection of material on the Department of Health website. One document was put on the website on 13 December, and another was added the same day. One of those documents covers the outputs from all six work streams that we have been pursuing—personalisation, integration, financial services, quality, prevention and so on. It says to the Government that a cap on care costs at between £50,000 and £60,000 would, in their view, stimulate a market for financial services. Who are they? Most of the big players in the sector. Why are they at the table? Because we realised that part of any reform of funding is serious about having a role for the financial services market needs to engage meaningfully with it. That is what we have been doing over the past few months, and I will be happy to ensure that these documents get to the Committee.

Q640 Chris Skidmore: In terms of the modelling you are doing, obviously a key aspect of whether Dilnot is going to succeed will concern momentum and to what extent you are able to get new entrants into the market fast enough for there to be an uptake, and whether the funding model will work fast enough. At the moment, the number of products available can be counted on two hands, and the number of people taking them up is below 10,000, or something. Has any modelling been done to show what you would need once a policy was implemented, and how fast you would need people to sign up to it, in order to make it viable?

Paul Burstow: The various factors that you would need to take into account to construct such a model are quite complicated, so there has not been detailed modelling. There has, however, been a lot of detailed discussion with the industry about how it would respond in the event of different levels of cap. As I said, we have heard back from the sector that in its view, even a cap as high as £60,000 would create sufficient space for more entrants with more products. Those products are not about insurance per se; they are often about the use of pension savings through annuities linked to disability needs, or through a new generation of equity release products. A variety of those sorts of things would allow people to access the various sources of wealth that currently are not perhaps as well deployed in supporting care needs as they might be if the financial services industry felt it was an environment in which it could operate.

Q641 Chris Skidmore: At the same time, local authorities were encouraged to roll out their own sort of separate asset-release schemes.
Paul Burstow: That is a deferred payment.

Q642 Chris Skidmore: In terms of the insurance modelling, if local authorities are offering asset deferred payments, does it look as though packages will tend to centre more around pension-based packages rather than equity? Because if you have the local authority system in place, you will not have any need to take up an equity-based insurance package.
Paul Burstow: That comes back to the earlier conversation we were having about eligibility and where eligibility falls. Depending on where you set that, there will still be a space between the point at which a person might want to start planning, preparing and future-proofing their home and so on and the point at which they would be eligible for any consideration either by state support or by being in the meter to get to a cap. There is a space there for those sorts of products to allow people to plan, who are prepared to use resources differently.

Q643 Chris Skidmore: Very briefly, we have talked about this subject’s being highly controversial and we have mentioned various papers that have already picked up on what is ongoing. A concern of mine is that the traditional view of the press has been of people having to sell their house to pay for their long-term care, and therefore Dilnot was seen as a panacea, whereby your house would somehow be preserved. That is not necessarily the case. We looked at domiciliary care. I wondered whether you wanted to clarify what you felt on Dilnot, which does not necessarily protect the home. There may be a gulf between the discussions that are ongoing and any policy, and the expectation that Dilnot will completely protect the family home.
Paul Burstow: The thing to say about the Dilnot Commission report is that it did not offer us a blueprint; it offered us a design guide. There is a whole series of parameters that you can move up and down, and that has an impact on the extent to which you do or do not protect assets and who you incentivise to behave in certain ways. The key things
here, if we are to change the demand curve, are about how we get people to plan and prepare earlier and how we help people through better advice, information and care navigation to use the resources they have, and the resources in their communities and private and other services, to meet those needs. That is the sort of set of things that we are wrestling with as a result of the inputs we have had from the engagement over the autumn, the work from the Law Commission and Andrew Dilnot’s work, which will come together in the White Paper in a few months’ time.

Q644 Chris Skidmore: Dilnot himself spoke about the crucial need to have some information and advice, and to make sure that is readily available. I guess that will be in the White Paper as part of the strategy.

Paul Burstow: Yes, we will amplify it. We have said a bit about how we see that being very much a universal offer. It is a key intervention at a very early stage—the provision of good-quality, reliable information and good-quality navigation of what the possibilities are. That itself could have quite a profound effect in terms of how people then choose to use their resources going forward. As I was saying, the research evidence shows that people dramatically underestimate how much they need to adapt their properties to be able to live in them well, safely and healthily for many years to come.

Q645 Chris Skidmore: Just one more point—moving on from Dilnot. Dilnot did not cover residential care and did not cover living costs of up to £7,000 to £8,000. That will still be the framework within which we operate for the White Paper, I imagine.

Paul Burstow: Dilnot covers both domiciliary and residential. It covers the whole spectrum. What we will set out in the progress report is what conclusions the Government have reached at the time we publish the White Paper.

Chair: Carefully chosen words.

Q646 Valerie Vaz: Minister, you mentioned the Law Commission earlier. You said that there were 76 recommendations. Is it possible for you to tell the Committee roughly what you are likely to accept and not accept?

Paul Burstow: Seventy-six recommendations—there are many in there.

Q647 Valerie Vaz: I am just asking for a broad answer from you. I do not expect you to know each individual one, but if you do, that would be great.

Chair: If you do, please write to us.

Paul Burstow: Thank you very much. That will be a feat of memory, let alone anything else. There are a number on which we have already given indications about our view. For example, we have made it very clear that we intend to legislate in the safeguarding area to place safeguarding boards on a statutory basis, and to establish clearly the duty of co-operation between different agencies. We have indicated that we are very sympathetic to the recommendations for moving the status of carers on to the same basis as service users in terms of entitlement to assessments and the follow-through of services. That is quite an important shift in terms of meeting some of the concerns that Barbara Keeley raised earlier. We have also indicated issues about having a universal offer about information, and the duties that would sit around that. Those are the three that we have already particularly said. We are working through a whole host of others. Clearly, if we were to implement a funding reform, we would need to look clearly at the recommendations that have been made about eligibility—the commission talks about a standardised approach—and at issues around assessment. We would need to look at assessment anyway if we were to implement the carers recommendation.

What we have said publicly as a Government is that we see the current legal framework as being well past its best-before date. It really does provide an obstacle to implementing many of the changes we need to see. In fact, one of the reasons we believe that some of the policy changes that have been attempted over the last decade or more around personalisation have not stuck in the system is that the system defaults back to a legal framework that does not accept them, so it rejects them when the going gets tough. We need to reset the legal framework to make it fit.

Q648 Valerie Vaz: Speaking about a legal framework, did you ask them to look at the legal framework around integrating health and social care?

Paul Burstow: The Law Commission as part of its work looked at the draft legislation that we were producing when we produced the Health and Social Care Bill, and certainly we would welcome the Law Commission’s views as and when we complete the drafting process.

Q649 Valerie Vaz: Did you ask them to look at that?

Paul Burstow: They looked at it, yes.

Q650 Valerie Vaz: They said that you didn’t.

Paul Burstow: They looked at the Health and Social Care Bill, and commented on integration.

Q651 Valerie Vaz: Are you accepting that? Is that an area that you are going to accept?

Paul Burstow: In 2008, when they were set the task of looking at the law review, they were not asked, as I understand it, to look specifically at integration. When it came to finalisation of their report leading up to May 2011, they did look at the draft Bill that the Government had published, to see the issues around—

Q652 Valerie Vaz: Specifically around integration?

Paul Burstow: Yes, around integration.

Q653 Valerie Vaz: And which you are accepting. They told us something different, but I just wanted to clarify that from you.

Paul Burstow: I will need to have a look at what they said to see why it is different.

David Behan: In their recommendations, they clarified the overlaps with other services, including the NHS, and also including housing, to pick up on
the theme of the Committee. They also commented on consistency between the legal frameworks, coming back to the point about incentives that I think you covered, and they wanted to ensure that they were supporting partnerships with requirements around co-operation. My recollection is that of the 73 recommendations, there is a recommendation around co-operation between health and local authorities in the way that they further their duties. I think the key issue was about the principles on which the future legislation should be based, and where they broke ground in many respects was saying that we need to set out the principles on which these systems should operate.

Q654 Valerie Vaz: And you will definitely take that on board. Okay. The other area, when they gave evidence to us, was that they said you asked them not to look at the definition of “ordinarily resident”. Why was that?
Paul Burstow: I was not privy to the decision, because it was made in 2008.
David Behan: Ordinary residence is an issue of administration rather than the law, and they were looking at matters of law rather than policy.

Q655 Valerie Vaz: I beg to differ, because you can define it, and it is defined in law. You can define “ordinarily resident”. In fact, it could make for much more clarity if you did that. There are other pieces of legislation that do define it.
David Behan: That is an interesting point, but currently “ordinary residence” is not defined in the law, so what the Law Commission looks at is what was defined in the law.

Q656 Valerie Vaz: Right, but they specifically said before us that you asked them not to look at that. I just want to clarify that.
David Behan: We asked them to look at the law, not policy. We drew a distinction between the law and policy.

Q657 Valerie Vaz: We did, but you specifically asked them not to look at the definition.
Paul Burstow: That request was made in 2008.

Q658 Andrew George: Minister, you have a reputation for taking up the role of highlighting the importance of carers. They are often overlooked, and you are well aware, of course, that estimates—I think informed estimates—suggest that up to £119 billion is saved, in effect, by the provision of care from informal carers. Apart from the carers strategy published last year, do the Government—your Department—intend to ensure that the role of carers will be at least acknowledged and dealt with in the White Paper?
Paul Burstow: Yes. It is also being embedded in the changes that we are making to the NHS through the Health and Social Care Bill. Carers feature in many aspects of the patient-involvement requirements much more explicitly than ever before. We have been talking about the extent to which the central direction and rolling out of things works. In opposition and in government I have been critical of the fact that although the previous Administration rightly focused on the need to people getting access to carers’ breaks and so on, demonstrably it did not happen as much as it should have. We are seeing similar difficulties in terms of securing that policy goal. That is why the operating framework that we published for this coming year, compared with the one that we drafted in our first year, is much more explicit than ever before about what we expect the NHS to deliver against our commitments on carers.

Q659 Andrew George: That is helpful, of course, but as your own record shows, although the Government estimate that there are about 5 million carers, another estimate is 6.4 million, which is about 15% of all households. This is a substantial issue, yet only 4% of carers receive any kind of assessment and the latest information suggests that that figure is falling rather than rising. To what extent are you satisfied that carers are getting the support that they deserve, are informed about their rights and the support that might be available to them and are becoming more rather than less isolated in the community?
Paul Burstow: I am certainly not satisfied and expect both the NHS and social services to do more. That is why, in the operating framework for 2012–13, we have said to them that the NHS has to collaborate with carers’ organisations and with its local authorities to agree a carers’ plan for its locality, drawing on the strategy you just mentioned. It has to be explicit about that and has to sign it off with its local authority; it has to spell out the financial contribution it is making to support carers; it has to identify how many carers’ breaks there will be; and it has to indicate the numbers. All of that has to be published to aid transparency.

On your point about the numbers of assessments and packages, we have one year’s figures showing a slight dip after a significant rise over a number of years. So yes, we need to watch that carefully. That is why one key priority in the strategy is for us to focus on identification of hidden carers and why we are working with the Royal College of General Practitioners on a series of pieces of work to really elevate the profile of carers within the GP community, as a key way to identify them. That is why we are working with organisations such as Sainsbury, which is introducing a new scheme shortly to identify people who do a double shop. Doing a double shop is a good indicator that someone is buying for someone else who they are caring for. That has been successfully trialled in Torbay. I visited the shop in Torbay while visiting the care trust, which was doing some interesting work, too.

Q660 Andrew George: You said in your earlier answer to me that your route to carers is through carers’ organisations, but few carers have the time or the ability to join such organisations. Surely, one route to them would be through the cared for, who are, after all, registered in some way and known about by the state, and through local authorities or the health service.
Is it not appropriate, given an earlier answer that you gave me, that when assessing the needs of those who require care, you consider them in the context of the support that might be available to them from family, friends and the wider community? In those circumstances, don’t you think that that is the route by which you should be identifying where the carers are and what support they need?

Paul Burstow: Yes, and we are. In the strategy, we identified the need to have a whole-family approach to assessment as a key part of that, so that you are not just assessing the person who needs care and support but looking at the whole family’s circumstances in terms of what support they can give. Also, you should not be making assumptions about who will provide care. Again, that is the reason we are collaborating with the Royal College of General Practitioners on work that they are doing to elevate the priority and visibility of carers. When a carer comes to the GP’s surgery with someone they are caring for, they should not be invisible. They should be a part of the conversation and they should be identified as a carer as well.

Q661 Andrew George: But a 4% assessment is still, you have to accept, woeful. I would hope that the White Paper and the future strategy would look at ways to assess that. You say that it has increased significantly, but to increase significantly to only 4% is rather woeful, I am sure you will agree.

Paul Burstow: I certainly agree that there is an awful lot more that we need to do, and we will set that out in the White Paper. There are a number of things we are doing, and the strategy that we have set out provides that. I agree with you that we need to find various ways of engaging with carers. It is one of the reasons why we have maintained the Standing Commission on Carers, which is clearly essential. If you are going to enable carers to live outside the home in which they are often tied providing care, is it not essential that you have discussions with the Department for Work and Pensions?

Paul Burstow: In terms of flexible working, the conversations are with BIS and my colleague Edward Davey, who has been leading on the consultations around extending the rights to request flexible working, meaning that there is an opportunity to widen the numbers of carers who currently have access to flexible working in the future. Good progress is being made there. I know that he is seized of the importance of supporting carers in that way.

Chair: A sure-fire way to find a teenager in the house as well.

Barbara Keeley: The Minister knows I have proposed a Bill for a number of years on the identification of carers and directing them to sources of support. It is a shame that that issue keeps being ducked—by the previous Administration as well as this one. It is quite easy to identify carers. GPs control their lists. They find people with particular long-term conditions or who have just had a stroke or who have cancer. The hospital discharge does the same. That is the point at which to say, “Who is going to be the carer for this person?” The other place where identifying hidden carers needs to be done is in schools, where an alert teacher can notice a young carer. I drafted a Bill with some help from outside in 2006. Why do we keep ducking this issue? This session has been all about ducking the issues. This is ducking it—identifying carers through a double shop at Sainsbury’s when GPs could be required to do so through their contracts, as they are expected to give injections or do certain follow-ups. Are we taking this issue of our commitment to carers seriously at all? It is not that there is not a way to do it. I have provided a way to do it. I will send you again, Minister, a copy of my Bill. Let us not get into shopping as a way of identifying carers.

Paul Burstow: What I would say, Barbara, is this. What we are not doing is saying that there is one magic bullet that allows you to identify all the carers in this country. Your Bill is certainly not a magic bullet, either.

Q664 Barbara Keeley: It would go a long way.

Paul Burstow: That is why I said in my remarks that one of the things that we are doing as a Government, which has not been done before and which we think will make a significant difference, is that we are actually concentrating on raising awareness of the issue among the GP population. It has not been done before.

Q665 Barbara Keeley: You could require them to do it.

Paul Burstow: That is one of the things that we are doing. As for our comments on the initiative by Sainsbury’s, rather than me attempting to defend that proposal—which I think is very good—it would be better if I sent you some of the figures that came out of the collaboration between Torbay Care Trust and Sainsbury’s in terms of the numbers of people identified as carers. I would have thought that we should share in common a desire to identify more carers and make sure they get our support.

Q666 Barbara Keeley: GPs and hospitals.

Paul Burstow: And try as many different routes to doing just that.

Q667 Rosie Cooper: Sainsbury’s knows about carers better than GPs.

Paul Burstow:—rather than having a one-size-fits-all approach, which I do not think will work.

Q668 Chair: Do you want to pursue this?
Q669 Rosie Cooper: I do. As for this Sainsbury’s nonsense headline-grabbing idea, can you tell me how Sainsbury’s identifies those doing a double shop? Using a store card? How does it identify them? When it has identified them, what does it do? Who does it tell? Which data protection nonsense does it breach? Does it ask me if I am a carer? Yes, I am. Have I been a young carer? Yes, I was. How does this all work? Once you are spotted as a potential carer in Sainsbury’s, look out. What happens?

Paul Burstow: Let me go through some of that. I spent a bit of time when I was in Torbay looking at their piloting of this and the way in which they have unpicked those various questions. What they do is very simple. They do some basic training of their staff on checkouts—to be alert to double shoppers. They provide them with some additional information in their shopping bags and they follow that through in terms of the numbers of people who then present themselves to the local authorities as possibly being carers. It then triggers the carers’ assessment processes and so on.

What I am not suggesting—and please do not run away with the idea that I am—is that this is the solution to the identification of carers. It is a contribution to the identification of carers. It is wrong to denigrate a supermarket which chooses to act in a socially conscious way and engage in this particular programme.

Q670 Rosie Cooper: I think you will find that I am rather more amused by a Health Minister who appears before this Committee and has made the level of contribution and increased our understanding of where the Department is today because frankly I am just astounded at what I have heard. It has not increased my knowledge one jot. We have had a lot of good contributions and increased our understanding of where the Department is today because frankly I am just astonished at what I have heard. It has not increased my knowledge one jot. We have had a lot of good contributions and increased our understanding of where the Department is today because frankly I am just 

Q671 Chair: Before we pack up and go home, could we have a brief series of questions on personalised budgets?

Q672 Dr Wollaston: Also on the subject of carers, should there be greater flexibility for allowing the personalised budget to go towards employing carers if that is the choice of the individual?

Paul Burstow: Sorry, I didn’t quite catch the question. Can you repeat it?

Q673 Dr Wollaston: Going on to personalised budgets, do you think that there should be greater flexibility to allow carers to be family members employed through personal budgets?

Paul Burstow: There already is some flexibility—I know this from my own constituency work as much as anything else—to allow people in certain circumstances to be able to employ a family member in those situations, so that flexibility is there now. If we need to clarify it further as a result of your inquiries, we would certainly want to do that.

Q674 Dr Wollaston: There are certainly some people who are being prevented from spending their personal budget in that way.

Paul Burstow: If there is a need for additional guidance to make it absolutely clear and put it beyond doubt, that is something we would want to do.

Q675 Andrew George: Can we have a written note on that?

Paul Burstow: Yes, of course.

Q676 Dr Wollaston: Returning to carers, do you think that assessments should be carer blind? Should we start running the meter towards a care cost, taking into account the contribution for carers to make it fairer to individuals or are we de facto saying that the system would collapse because there would not be the funds within it without using those costs?

Paul Burstow: I certainly think that what we said in the carer strategy is that we need to take a whole family approach to assessment, and to look at the whole family circumstance in terms of designing the meter. One of the problems I have coming to the Committee at this stage is that there are lots of issues of policy development that are not concluded. I cannot present to you the White Paper setting out all those policies. I understand that that is frustrating for members of the Committee, who would like me to air all of the conclusions that we have reached or will reach over the next few months. I hope, Mr Dorrell, that your Committee, as it clearly has been doing during its hearings on this, will provide us with some further stimulating recommendations that we can take into account in that White Paper.

Chair: That is for others to judge, but we will do our best.

Q677 Grahame M. Morris: I want to put something to you that was put to the Committee when we visited Lancashire, following meetings with groups of carers and with officials and politicians from the local authority. You mentioned personalised budgets being a game changer earlier, and one of the anomalies that they pointed out was the pressure on local authority day care services as a consequence of the personalised budget holders not being allowed to purchase care from the local authority. Is that something that the Government are aware of and that they intend to address?

Paul Burstow: That is a point that Mr Tredinnick raised earlier, and the point that I made was that personal budgets allow people to still purchase services from their local authorities, so it allows them to have greater independence and ability to shape the service they want, and we think that allows us to address that concern.

Q678 Grahame M. Morris: That was not the information that was given to us, unless I have misunderstood.
Paul Burstow: Would it be possible for the Committee to let us have whatever it is that you have and then we can give a proper response?

Grahame M. Morris: I would be grateful for that.

Q679 Chair: I am sure that we can do that. May I ask a question about personalisation? I think that everybody is familiar with the arguments in favour of personalisation as a means towards greater engagement by the individual in the design of services and greater empowerment of individuals—all of that is clear. That is one set of issues. Another set of issues is portability around the country, which Andrew George has covered. Is there not a set of concerns on the other side of the spectrum that we need to be aware of, namely that the more you define the individual’s need in terms of money and in terms of the formula in order to allow personalised budgets, the more difficult you make it for the system to reflect the precise circumstances of a family or a particular set of individuals and the more you move away from designing service towards, in effect, reinventing social security? The Department for Work and Pensions looks at the circumstances of the individual and defines them in monetary terms, but that is absolutely not what the NHS, at the other end of the spectrum, does. I wonder whether there is a conflict of cultures here that has not been fully reconciled.

Paul Burstow: It is an important part of how we reform the system to understand that we are not introducing a scientific process where there is an absolutely right answer for an assessment of human beings’ needs in terms of them being able to maintain their independence, their dignity and their ability to integrate and be part of their community. There is not just a thing you can do by tick-box rote to do that. I think that that comes out strongly from everything we are doing.

In terms of the Law Commission stuff—I think this is very important—and the idea that you have a set of clear principles that are about the individual and about outcomes, and not just about provision of services, the National Assistance Act 1948 is all about providing a service to meet an assessed need. The new social care legal framework, as recommended by the Law Commission—we have given a number of indications of the areas where we definitely want to pursue it—is very much about saying that it is not just about the services. It is about what you need in terms of your life—the ability to have education, the ability to be in your community enjoying social activity and so on. They are listed as the things that should go into the drafting of a Bill, and we see that as being an important and fundamental shift. Although, on the one hand, that has the appearance of being more social security because you are monetising, it firmly pulls it the other way because of the statutory framework. Landing that well and implementing it effectively over the next few years is very much the task that we are focused on and determined to deliver.

Q680 Chair: But are you cognisant of the fact that, if this is interpreted as a set of defined circumstances on national criteria, you are moving in the direction of a rights-based system where the rights are ultimately converted into money, rather than into a set of services that are flexible to the individual’s needs?

Paul Burstow: That is going to be the very key thing in the design of the assessment processes—assessments that are about assessing to deliver outcomes and commissioning that is about commissioning to deliver outcomes, and not just procuring a lump of service. One of the criticisms that we have heard about the way that a lot of social care is currently commissioned in this country, and I certainly think that it is a fair criticism, is that we commission far too much not on quality but on quantity and price. We need to move to a situation where we are commissioning for outcomes, and that has to be right through the system down to the individual with the use of their budgets, in terms of the plan that they have to meet those outcomes.

Q681 Chair: But even just talking in terms of outcomes creates another potential conflict, doesn’t it? You may have a view about what the outcome is, which represents best practice, good quality and so forth, and individuals may choose a different outcome, which more closely reflects their views. That is part of the conflict that potentially arises. The reason for this line of questioning is to test the extent to which the Department has thought through the implications of what sounds, at first principles, like common sense, but once you apply it into the guts of a very big spending programme you may create some conflicts that have not been fully reconciled.

Paul Burstow: Also, this goes back to some of the questions about facts. In the end, we are living within a resource envelope and we need systems that make it as transparent and as clear as possible how resources are being allocated. So you are absolutely right that, in designing not only the policy but the detailed implementation, getting that right so that it is transparent and people can see how finite resources are being used to deliver the maximum public good is absolutely one of the tests, both for the White Paper and its subsequent implementation.

David Behan: If I may, Chair—

Paul Burstow: What I meant to say.

David Behan: No, no, perish the thought. The interesting thing is the proportion of people who are taking a direct payment as opposed to a personal budget and by far the higher proportion are taking it as a personal budget. In effect, there is a mixture, between what people will procure themselves—that might relate to your point about whether this measure is similar to a benefit—and what they arrange and take from the state, which is already pre-arranged for them. The balance is far more towards a personal budget than it is towards direct payments.

If you look at the figures and trends over the past decade or so, you will see that there is a great attraction around personal budgets rather than around the direct payments. That means that the presentation of this issue as an either/or is that, because it is providing people with choice, people want to exercise some choice. There was talk earlier about what people might do differently in terms of singing lessons for COPD. But my guess is that that will be supported by some slightly more formal and perhaps traditional
services, which will also be appropriate to meeting those needs.

I think that the emergent evidence is that people are having a mixture of the traditional and perhaps the not-so-traditional, so it is not really an either/or. I think your question is really about what the mixture is between these things and how that is taken forward. I think that we are trying to apply some thought to what that will mean going forward and also applying that thought in relation to personal health budgets for people with long-term conditions, which I think was part of an earlier question from the Members.

Chair: Thank you. We are running out of time, but we have a question from Dan.

Q682 Dr Poulter: I just have one question, building on what the Chairman just said and some of the concerns that were raised. Isn’t there also a risk with personal budgets that you may have some local authorities—we have already seen this—that, when they look to make cost savings, might see personal budgets as a way of closing down some services and focusing emphasis on personal choice? More expensive local services may be closed down because the drive to run a more comprehensive local social care network and health network may be compromised by the drive for personalisation. Is there not a risk that local authorities may take that approach?

Paul Burstow: Of course there is that risk. It would be crazy to pretend otherwise. Therefore, in terms of the implementation of these policies going forward, it is going to be a case of asking what steps you take to mitigate that. Part of it is about making sure that the criteria you use around eligibility and the resource allocation decisions that are being made are as transparent as possible, and that those discussions are held in a way that allows the views of service users, carers and so on to have an impact. That is the best safeguard we can put into ensuring that you are getting the right outcomes from the money going in.

Q683 Dr Poulter: Yes, because there is a tension there. We might say that we support personal choice, which we recognise is to some extent a very good thing, but, at the same time, by supporting the funding of that, we lose some of those comprehensive services on a local level that service users and carers very much value.

Paul Burstow: The work and research that has been done by IBSEN, the group, and POET, and, indeed, last year’s National Audit Office report on markets have all looked at issues around personalisation. The general conclusion was very clear: that people valued the extra control that they gained back over their lives as a result of having access to either a personal budget or a direct payment.

Q684 Dr Poulter: But you accept that tension?

Paul Burstow: Yes. Of course there is a tension. Chair: We have covered a lot of ground. Thank you very much for your patience and good humour.
Written evidence from the Department of Health (SC 01)

Summary

The Coalition: our programme for government set out the Government’s clear commitment to reforming the system of social care to provide much more control to individuals and their carers, and to ease the cost burden that they and their families face.

Since then the Government has taken a number of steps to improve social care provision in England and has committed to publishing a Care and Support White Paper in the spring.

In October 2010, the Government prioritised funding for adult social care in the Spending Review, allocating an additional £2 billion per annum by 2014–15 to support the delivery of social care.

The Government followed this by publishing its Vision for Adult Social Care in November 2010, which set a new agenda for adult social care in England. It focused on commitments to:

- break down barriers between health and social care funding to incentivise preventative action;
- extend the rollout of personal budgets to give people and their carers more control and purchasing power; and
- use direct payment to carers and better community-based provision to improve access to respite care.

The Government has also set out its position in relation to strategies published by the previous government through the Carers’ Strategy refresh and a revised implementation plan for the previous government’s Dementia Strategy.

More recently, the Government has received two independent reports that make recommendations on how to reform the social care system.

In May 2011, the Law Commission’s review into the legal framework for adult social care reported making a series of recommendations to government for the wholesale reform of the law.

The Commission on Funding of Care and Support, set up by the Government when it came into power, reported in July 2011 with recommendations for changes to how the cost of care is shared between the individual and the state as a partnership.

The Government is now engaging on a broad range of areas for social care reform that covers the recommendations from these two reports and more. This will inform a Care and Support White Paper and progress report on funding reform to be published in the spring.

This written evidence submission provides more details on the actions taken by the Government since it was formed and responds to specific issues with the current system raised by the Health Select Committee in its terms of reference, namely access to and charging for social care and economic regulation of the system.

Coalition Agreement

1. The Coalition: our programme for government set out four areas for action in achieving the aim of providing more control to individuals and their carers and easing the cost burden that they and their families face:

- establishing a commission on long-term care to report within a year;
- breaking down the barriers between health and social care funding to incentivise preventative action;
- extending the greater roll-out of personal budgets to give people and their carers more control and purchasing power; and
- using direct payments to carers and better community-based provision to improve access to respite care.

2. The Government moved quickly to establish the Commission on Funding of Care and Support in July 2010 (discussed in more detail below) and showed its commitment to social care in the Spending Review.

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1 The Coalition: Our Programme for Government, HM Government, 2010
2 A Vision for Adult Social Care: Capable Communities and Active Citizens, Department of Health, 2010
3 Recognised, valued and supported: next steps for the Carers’ Strategy, Department of Health, 2010
4 Living well with dementia: A National Dementia Strategy, Department of Health, 2009
5 See www.justice.gov.uk/lawcommission/docs/lc326_adult_social_care.pdf
6 See www.dilnotcommission.dh.gov.uk/our-report/
7 Caring for our Future: shared ambition for care and support—see www.caringforourfuture.dh.gov.uk/
The Spending Review

3. In the Spending Review, the Government allocated an additional £2 billion per annum by 2014–15 to support adult social care which, together with an ambitious programme of efficiency, it believes will enable local authorities to maintain the current level of service provision.

4. This assessment has been corroborated by the King’s Fund. Its publication on social care budgets following the Spending Review showed that the settlement would be sufficient if local authorities made efficiency savings of around 3.5% per annum in adult social care. The Department agrees broadly with this analysis.

The Vision for Adult Social Care

5. The Vision for Adult Social Care published in November 2010 sets a new agenda for adult social care in England, seeking to make services more personalised, more preventative and more focused on delivering the best outcomes for those who use them. It was the Government’s first step towards the Care and Support White Paper.

6. The vision is built on seven principles.
   - Prevention—supporting people to maintain their independence;
   - Personalisation—individuals not institutions taking control of their care;
   - Partnership—care and support delivered in a partnership between individuals, communities, the voluntary and private sectors, the NHS and councils;
   - Plurality—the variety of people’s needs matched by diverse service provision;
   - Protection—effective but proportionate safeguards against the risk of abuse or neglect;
   - Productivity—delivering high productivity and high quality care and support services; and
   - People—drawing on a workforce who can provide care and support with skill, compassion and imagination.

7. Further detail is set out below on the particular areas highlighted in the terms of reference of this Health Select Committee inquiry.

Personalisation and Personal Budgets

8. The Government believes that to secure the best outcomes for people, they, not service providers or systems, should hold the choice and control about their care. With choice and control, people’s dignity and freedom is protected and their quality of life is enhanced. The personalisation agenda is focused on ensuring that individuals can take control of their care.

9. Where personalisation has taken root, it works and is popular with users and carers. A report from the Office of Fair Trading showed that direct payments made people happier with the service they receive. Two reports on individual budgets said people, including carers, enjoyed the enhanced control over their care.

10. To ensure that all can benefit from personalisation, the Government wants to see the people who are eligible for ongoing social care provided with a personal budget, preferably as a direct payment, by April 2013.

11. A personal budget is the amount of council funding apportioned to individuals to manage their care costs in line with an agreed support plan, following a full community care assessment and financial allocation by the council. An individual can take a personal budget in the following ways:
   - as a direct (cash) payment, held by the individual;
   - as an account held and managed by the council in line with the individual’s wishes, or placed with a third party and used by the individual in agreement with the provider; or
   - as a mixture of the above.

12. A consequence of personalisation is that people will increasingly take their own decisions about how to balance their new freedoms with a sensible approach to risk. The vision therefore also calls for an increase in preventative activity in local communities, to keep people independent for longer.

13. The latest survey from ADASS indicates that the total number of personal budgets delivered by councils across England has doubled to 338,000 in the year to March 2011. This means that a third of the approximately one million eligible people supported in community settings now receive a personal budget, and half of these are over 65 years of age.

8 See www.hm-treasury.gov.uk/spend_sr2010_documents.htm
9 Social care funding and the NHS? An impending crisis, The King’s Fund, 2011
12 Individual Budgets: Impacts and Outcomes for Carers (Social Policy Research Unit, University of York, 2009).
13 See www.thinklocalactpersonal.org.uk/Latest/Resource/?cid=8984
14. To support the drive towards increased personalisation the adult social care sector published a partnership agreement, *Think Local, Act Personal*, in January 2011, following a period of consultation. The agreement recommends how councils, health bodies and providers should work more efficiently to personalise and integrate service delivery across health and adult social care. Over 30 organisations across the sector, including local government, health, independent and community organisations, have signed up to the key principles underpinning it.

15. In addition, a number of best practice documents on different aspects of personalisation were published at the same time as the vision for adult social care to support the increased roll-out of personal budgets.

16. Another part of the Government’s personalisation agenda is the framework for Personal Assistants which offers support for people with care needs as well as the personal assistants they employ. The Individual Budgets Evaluation Network (IBSEN) study suggested that 59% of those receiving personal budgets spent part or all of their budgets on Personal Assistants.

Integration

17. The vision also sets out opportunities to improve integration between health and social care over the coming years. There are three areas that the Government is focusing on in the short-term.

18. Firstly, proposals in the Health and Social Care Bill seek to improve integration between health and social care in the modernised system. These are:

- duties on the NHS Commissioning Board, Clinical Commissioning Groups and Health and Wellbeing Boards, to encourage integrated working and commissioning at all levels;
- requirements for local authorities and Clinical Commissioning Groups to undertake a Joint Strategic Needs Assessment (JSNA) through the Health and Wellbeing Board, leading to a Health and Wellbeing Strategy and statutory guidance setting out that Clinical Commissioning Groups’ commissioning plans should be in line with the Strategy as well as the JSNA; and
- requirements on Monitor to support the delivery of integrated services for service users where this will improve quality of care and efficiency.

19. Secondly, following on from the successful NHS Future Forum listening exercise, the Future Forum has been asked by Ministers to continue to work with a full range of health and local government stakeholders. One of the key issues it has been asked to explore is how best to exploit the NHS, social care and public health modernisation programmes to accelerate the redesign of care so that it is more integrated and focused on the needs of people who use services. This work is being taken forward in partnership with the Caring for our Future engagement.

20. Finally, the Spending Review provided funding for the NHS (£1 billion per annum by 2014–15) to transfer to local authorities for social care which will support improved integrated working between health and social care. Of this money, up to £300 million per annum has been earmarked for reablement to help reduce demand upon social care services.

21. Primary Care Trusts (PCTs) will need to work with local authorities to agree where the money should be invested, with a shared analysis of need and common agreement on what outcomes need to be met. The Department has been clear that the funding should be used to support those interventions where there is mutual benefit for both PCTs and local authorities, whilst providing local flexibility so that PCTs and local authorities can respond to the JSNA for their area.

Portability

22. Current guidance to local authorities, sets out that:

“When a service user permanently moves from one council area to another […] the council whose area they move into should take account of the support that was previously received and the effect of any substantial changes on the service user when carrying out the assessment and making decisions about what level of support will be provided. If the new council decides to provide a significantly different support package, they should produce clear and written explanations for the service user.”

23. The vision makes clear the Government’s support in principle for greater portability of assessment for users and carers. It states that:

“A critical outcome for many people is that they can move from one part of the country to another without having to go through unnecessary multiple assessments and uncertainty. This is particularly important for people who want to pursue educational or employment opportunities, and the system

14 See www.thinklocalactpersonal.org.uk/Browse/ThinkLocalActPersonal/
15 See www.thinklocalactpersonal.org.uk/LatestResource/index.cfm?cid=8560
16 Working for personalised care: a framework for supporting personal assistants working in adult social care, Department of Health, 2011
17 Ibid (10)
18 Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care, Department of Health, 2010
should support rather than hinder these goals. We want to see greater portability of assessments, and will consider how to pursue this in the light of the work of the Law Commission and the Commission on Funding of Care and Support.”

24. The Law Commission supported greater portability of assessment, recommending that there should be a specific provision to promote co-operation between local authorities when individuals are moving areas, and a power to make regulations that ensure there is continuity of support when individuals move areas.

25. The Commission on Funding of Care and Support recommended that anyone moving from one local authority to another should retain their needs assessment until the new local authority assesses that individual. They also recommended that the receiving local authority should have a duty to meet all eligible care needs in the intervening period.

26. Government is now considering the recommendations of the two commissions and will set out its proposals on portability in the Care and Support White Paper.

Carers’ and Dementia Strategies

27. Alongside the Vision for Adult Social Care, the Government also published a revised strategy on support for carers and implementation plan for people with dementia, both of which are relevant to delivering the Government’s objectives in social care.

28. The Carers’ Strategy refresh, Recognised, valued and supported: next steps for the Carers’ Strategy, prioritises future actions to ensure the best possible outcomes for carers and those they support. Following a call for views over the summer, government identified four priority areas for action. These are:

- supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages;
- enabling those with caring responsibilities to fulfil their educational and employment potential;
- personalised support both for carers and for those they support, enabling them to have a family and community life; and
- supporting carers to remain mentally and physically well.

29. To support delivery of these priorities the Strategy provided:

- additional resources in the NHS to support carers to take breaks from their caring responsibilities over the next four years;
- additional resources for GP training, to increase GPs’ awareness and understanding of carers’ needs; and
- support to patient-led and condition-specific voluntary organisations to enable them to focus on supporting carers through a Reaching out to Carers innovation fund.

30. The Government has also published a revised, outcomes focused implementation plan for the National Dementia Strategy.19  The plan set out for health and social care localities and their delivery partners the priorities for delivery in 2010–11, the Strategy’s fit with the new health and care system and with the NHS Outcomes Framework.

31. Within the 17 objectives of the National Dementia Strategy, four key areas were identified as priorities. There are:

- good-quality early diagnosis and intervention for all;
- improved quality of care in general hospitals;
- living well with dementia in care homes; and
- reduced use of antipsychotic medication.

32. To promote progress in these areas the Government has:

- provided additional funding to support the social care element of memory services to help identify people with dementia earlier and ensure more effective treatment and support;
- published commissioning packs to support clinical commissioning groups in designing and purchasing high quality dementia services;
- launched pilot dementia awareness campaigns in the Yorkshire and Humber and North West NHS regions focused on persuading people to seek an early diagnosis where they have concerns about the possible onset of dementia; and
- launched a national “call to action” on reducing the use of antipsychotic medication for people with dementia, in conjunction with the Dementia Action Alliance (membership of 74 organisations currently) and the NHS Institute.

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19 Quality outcomes for people with dementia: Building on the work of the national dementia strategy, Department of Health, 2010
The Law Commission

33. The state of current adult social care legislation has been roundly criticised as opaque, complex and
anachronistic. Over 60 years, a patchwork of legislation has grown and evolved, with more added from time
to time to mould the framework to different policy objectives, but without any substantial reform. There are
now around 30 different pieces of legislation which relate to adult social care, with the base statute still the
1948 National Assistance Act.

34. Adult social care has changed much over that period, but the law which drives it has largely remained
the same. The net result is often confusion, and sometimes inequity. For this reason, many have argued that
law reform is long overdue.

35. It was against this backdrop that the Law Commission proposed a review into the legal framework for
adult social care in its Tenth Programme of Law Reform—a proposal agreed by the previous government
in 2008.

36. The Law Commission’s project to review social care law consulted extensively, and spanned almost
three years, before reporting in May 2011. The final report made a series of recommendations to government
for the wholesale reform of the law.

37. The Law Commission’s final report identified a number of critical issues for reform, and its
recommendations cover a broad range. The recommendations relate both to the structure and the content of the
legislative framework.

38. In summary, on the structure of the legislative framework, the Law Commission recommended that
social care law should be simplified, with a single statute for adult social care in England which unifies and
updates the existing legislation. The new statute would be the first level of a three-level structure, which also
clarifies the status of secondary legislation and statutory guidance. There should be a consistent approach to
regulations and consolidated statutory guidance (a “code of practice”) to clarify the legal status and support
frontline practice. Other provisions that do not fit within the three-level structure should be removed.

39. With regard to the content of the legislative framework, the Law Commission made a number of
recommendations to rationalise existing legislation and create a coherent legal framework around core adult
social care processes, such as assessment, eligibility and provision of care and support. The report also proposed
new or updated legislation in a range of other areas, for instance around carers and adult protection, to
modernise provisions and to close gaps in the law. Finally, the Commission recommended new statutory
principles to act as a unifying purpose for the law, and provide clarity both for social care professionals
and users.

40. The Government welcomed the Law Commission’s report on its publication. The totality of the Law
Commission’s recommendations lay the foundations for social care law reform and it broadly reflects the
Government’s overarching aims and objectives: modernisation, simplification, consolidation and rationalisation.

41. Government is now considering the Law Commission’s recommendations alongside its broader ambitions
for reform in social care, including the proposals of the Commission on Funding of Care and Support, which
have further legal implications. The Care and Support White Paper in spring 2012 will incorporate its formal
response to the Law Commission.

The Commission on Funding of Care and Support

42. The Commission on Funding of Care and Support was set up by government in July 2010 and asked to
examine and provide deliverable recommendations on:
— how best to meet the costs of care and support as a partnership between individuals and the
state;
— how people could choose to protect their assets, especially their homes, against the cost of care;
— how, both now and in the future, public funding for the care and support system can be best
used to meet care and support needs; and
— how its preferred option can be delivered.

43. The Commission was also asked to judge funding models against set criteria, which included choice,
fairness, value for money and sustainability.

44. The Commission made a series of primary recommendations about a new funding model that it believed
met these objectives and in addition secondary recommendations about the wider social care system.

45. In summary on the funding model, the Commission recommended capping the lifetime contribution to
adult social care costs that any individual needs to make at between £25,000 and £50,000, citing £35,000 as
an appropriate and fair figure. Together with extending the asset threshold for those in residential care beyond
which no means-tested help is given from £23,250 to £100,000, the Commission believe that this would mean
that no one going into residential care would have to spend more than 30% of their assets on their care costs.
46. In addition to this the Commission also thought that:
— individuals in residential care should have to meet the costs of living, just as if they were receiving domiciliary care in their own home, recommending that costs should be fixed nationally between £7,000 and £10,000, subject to the affordability to individuals; and
— those who enter adulthood already having a care and support need should immediately be eligible for free state support to meet their care needs, rather than be subject to the means-test. Those who develop a care and support need during their working life should be assessed broadly in the same way as an older person, with the cap tiered to reflect differentials in their likely ability to accumulate assets.

47. In summary on the wider social care system, the Commission recommended a number of measures including a more objective assessment and eligibility system, improved information for carers and users and portability of assessment.

48. The Government welcomed the Commission’s work and its final report as “making an immensely valuable contribution to meeting the long-term challenge of an ageing population”. However, it set out that in the current public spending environment, the Government will have to consider the recommendations carefully against other funding priorities and calls upon constrained resources. Reform in this area would have to meet a number of tests including:
— whether the proposals would promote closer integration of health and social care;
— whether the proposals would promote increased personalisation, choice and quality,
— whether the proposals would support greater prevention and early intervention;
— whether a viable insurance market and more diverse and responsive care market would be established as a result of the proposals;
— what is the level of consensus that additional resources should be targeted on a capped cost scheme for social care; and
— what a fair and appropriate method of financing the additional costs would be.

49. Government is now using the Commission’s report as the basis for engagement with stakeholders on the fundamental issues for reform in social care. The Government will set out its response to the Commission on Funding of Care and Support in a progress report on funding reform in the spring.

Caring for our Future

50. Caring for our Future: Shared ambitions for care and support was launched on Thursday 15 September, and will last until early December.

51. It is an opportunity to bring together the recommendations from the Law Commission and the Commission on Funding of Care and Support with the Government’s Vision for Adult Social Care, and to discuss with stakeholders what the priorities for reform should be.

52. The Government wants to discuss what people’s priorities for change are and it has identified six key areas where it believes there is the biggest potential to make improvements to the care and support system. It asked a leader from the care and support community to help the Government to lead the discussions for each of the six areas as set out in the table below:

| Table 1 |
|-------------------------|-------------------------|-------------------------|
| AREAS                        | STAKEHOLDER LEAD       | POSITION AND ORGANISATION |
| Improved quality and developing the workforce        | Imelda Redmond         | Chief Executive, Carers UK |
| Increased personalization and choice                   | Jeremy Hughes          | Chief Executive, Alzheimer’s Society |
| Creating a more diverse and responsive local care market | Peter Hay              | President, Association of Directors of Adult Social Services |
| Supporting greater prevention and early intervention   | Alex Fox               | Chief Executive, NAAPS |
| Ensuring services are better integrated around people’s needs | Geoff Alltimes         | Chief Executive, Hammersmith and Fulham Council |
| The role of the financial services sector in supporting users, carers and their families | Dr Robert Varnam, Nick Kirwan | GP from Manchester, Assistant Director Health and Protection, Association of British Insurers |

20 Oral Statement to the House—Reform of Social Care, 4 July 2011, Hansard Column 1232
Together with the lead stakeholders, government will be attending events, holding meetings and listening
to the views of user and voluntary organisations, carers’ representatives, care providers, and local councils on
what the priorities for improving care and support should be. People can also submit views through local
groups and events and the Caring for our Future website.21

Later in the autumn, as part of the engagement, the Government will ask the six discussion leaders to
bring together the views they have gathered on support for the Commission on Funding of Care and Support
proposals, and the wider priorities for change.

This Health Select Committee inquiry provides a good opportunity to consider these issues in more
detail and will be a valuable contribution to the engagement and broader thinking on social care reform ahead
of the Care and Support White Paper and progress report on funding reform next spring.

This written evidence submission now goes on to consider some of the specific issues raised by the
inquiry’s terms of reference which have not already been discussed under the previous headings.

The Current System: Existing Variation in Access to and Charges for Social Care in England

Access to social care

Local authorities determine their own eligibility criteria in line with national guidance set out in
Prioritising need in the context of Putting People First. This guidance aims to assist councils with adult social
services responsibilities in determining eligibility for adult social care in a way that is fair, transparent and
consistent, accounting for the needs of their local community as a whole as well as individuals’ need for
support.

Local eligibility criteria determine the threshold at which a local authority will provide support in terms
of the severity of need.

Central government does not collect data on local authority social care eligibility.

Charging for social care

There are two systems for charging for social care, one for residential care and one for non-residential
care.

There is a national scheme for charging for residential care, based on statutory regulations. This applies
to all English local authorities. Under the Assessment of Resources Regulations 1992,22 a person with more
than £23,250 in capital is usually assumed to be able to arrange their own care. However, a local authority
may arrange care for a person with more than £23,250 if, for example, the person lacks capacity and has no
one to act for them.

Capital less than £14,250 is disregarded in the assessment of what individuals can afford to pay. For
capital between £14,250 and £23,250 the individual is charged £1 per week for every £250, or part of £250,
of capital they have above £14,250.

A care home resident who is supported by local authorities will contribute most of their income towards
the cost of their care, but, to ensure they have money to spend on personal items, residents are guaranteed a
weekly Personal Expenses Allowance (PEA),23 under section 22(4). The PEA is currently £22.60.

Local authorities have flexibility with regard to certain aspects of the charging arrangements for
residential care. For example, they can award a higher level of PEA in certain circumstances. They also have
discretionary powers to make deferred payments agreements with residents; this enables people to keep their
home on admission to residential care and for the duration of the deferred payments agreement.

Under section 17 of the Health and Social Services and Social Security Adjudications Act 1983, each
local authority has discretionary powers to charge for non-residential care.

The guidance on charging policies24 is issued under section 7 of the Local Authority Social Services
Act 1970; local authorities must have regard to it. The guidance states that charging policies should not reduce
a service user’s income below basic levels of Income Support, plus a buffer of 25%. As part of the assessment
of what a person can afford to pay, local authorities should also make a specific assessment of and allow for
their disability-related expenditure.

Government does not collect information on the exercise of local authorities’ discretion to charge for
either residential or non-residential care.

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21 See www.caringforourfuture.dh.gov.uk
23 the PEA is intended to be used to purchase items such as stationery, personal toiletries, treats and small presents for friends and
relatives;
24 Fairer charging policies for home care and other non-residential social services: guidance for Councils with Social Services
Responsibilities, Department of Health, 2003
The Current System: Economic Regulation of the Social Care System

68. There are important mechanisms and levers within the current social care system to safeguard the interests of all those using care services. Local authorities have specific legal duties to provide care (a local authority must provide residential accommodation for people who are in need of care and attention, which is not otherwise available) and should also be overseeing their local market and shaping its development. The Care Quality Commission (CQC) regulates adult social care in England, and registers providers of all care homes. It has the power to impose conditions upon the registration of, and ultimately close down, operators who are at risk of providing poor care because of their financial situation. However, the CQC core function is to regulate quality. It is not an economic regulator.

69. As in other markets, providers are regularly entering and exiting the care market—driving out poor quality providers and driving innovation. For instance in 2010, there were 142 new registrations (8,093 new beds) and 175 deregistrations (a reduction of 4,360 beds).25 To date, this has been resolved at the local level, with the National Audit Office (NAO) in its recent report *Oversight of user choice and provider competition in care markets*,26 concluding that exit or take over of care homes and domiciliary care providers is a feature of local care markets, and that normally other providers come in to run services with little or no impact on users.

70. However, a number of recent events and policy developments have led the Government to consider whether the current approach to market oversight is adequate, and whether there is sufficient protection for those reliant on care services.

71. The case of Southern Cross has highlighted that there are risks if a large provider falls into significant financial difficulty; with the NAO’s recent report recommending that “the Government needs further arrangements at a national and local level to protect users from provider failure”. A key issue raised by the NAO was that the Department of Health currently has no formal mechanism for dealing with a provider failure of the size of Southern Cross, where the cumulative impact could affect the delivery of essential services and that crossed local authority boundaries. The NAO also argued that, in the future, with more people directly commissioning their services—either as a self-funder or through personal budgets/direct payments—it will be important to ensure that their interests are properly protected.

72. The Government is now looking at the issue of oversight of the care market in detail, and has published a discussion document,27 which welcomes views to help shape policy in this area and will inform the Care and Support White Paper next year.

October 2011

Written evidence from the Social Care Institute for Excellence (SC 05)

1. The Social Care Institute for Excellence (SCIE) is an independent charity that improves the lives of adults and children who use care services by identifying and spreading knowledge about what works and by supporting the delivery of transformed, personalised social care services. We recognise the central role of people who use services and their carers, and we aim to ensure that their experience and expertise is reflected in all aspects of our work.

2. SCIE is pleased to have the opportunity to contribute to the Committee’s inquiry into social care. We recognise that the Committee’s terms of reference are very wide. We have focused our evidence on the quality and accessibility of adult social care, and on how services can be developed and modernised, rather than on options for funding care. That said, while we know that better use can be made of existing resources, we agree with the conclusions of the Dilnot Commission28 that the funding system itself is in urgent need of fundamental reform.

3. Summary of Key Points

— The social care sector has been grappling for some time with the challenge of reshaping and personalising adult social care services in the context of a steady rise in the number of older people and people living with disabilities and long-term conditions. Care costs are rising; eligibility criteria for access to publicly-funded services are becoming tighter; consequently levels of unmet need are likely also to be rising; demands on unpaid family carers are growing; there are concerns about value for money and cost-effectiveness; and the current system is widely perceived to lack fairness and transparency. A number of official and unofficial reports in recent years—from the King’s Fund, Joseph Rowntree Foundation and Dilnot Commission, to name but three—have echoed such concerns.

25 *Care of the Elderly: Market Survey 2010–11*, Laing and Buisson 2010
26 *Oversight of user choice and provider competition in care markets*, NAO, September 2011
28 *Fairer Funding for All*, Commission on Funding of Care and Support (July 2011).
— Whilst policy and system issues, such as eligibility criteria and portable assessments, are of central importance to well-functioning social care, from the point of view of the individual user of such services and their family carers, what really counts is that they can choose and access high quality services which treat them with dignity and respect. As recent Care Quality Commission reports into dignity and nutrition in health and social care settings remind us, this is unfortunately not always people’s experience. Yet in some ways there is no excuse for this—SCIE’s own work demonstrates how to safeguard people’s dignity and respect and we have defined clearly what makes for “excellent” care.29,30

— In a climate of rising demand and shrinking resources, not least when significant spending reductions need to be implemented quickly, local authorities may seek immediate solutions such as raising the threshold for access to services and increasing charges for home care. But this is an unsustainable and ultimately counter-productive approach. Those turned away or who refuse care because of the cost may well return later with significantly higher levels of presenting need. Research shows that better outcomes can be achieved for the same resources by increasing flexibility in patterns of service provision and use, and by promoting personalised approaches, to secure the best mix of formal, informal and community-based care and support.

— The relentless search for quality improvement needs to be driven by a combination of consumer power and choice and by the sector itself, as the localism agenda results in fewer top-down targets, fewer ringfenced grants, and an end to the assessment of council commissioning by the care regulator. All parts of the sector need to work together, along with health, housing and other services—recognising that older and disabled people’s lives are affected by the interaction of a wide range of services, of which social care is only one facet.

— There remains an unresolved tension between local responsiveness, with the aim of maximizing the contribution of active citizens within their communities and reducing demand for more intensive (and dependency-creating) care services, and the public’s hostility to postcode lotteries driving national guidance on eligibility for access to social care services. The two approaches appear incompatible, but may ultimately be resolved by a new legal framework which makes clear what is a clear universal entitlement, eg to an assessment of need, and what is legitimately for local resolution. This would strengthen the position of people entering the social care system and enable them to act as equal partners with professionals in assessment, support planning and the maintenance of wellbeing.

Improving Fair Access to Care Through Better Information and Advice

4. One of the biggest problems with the adult social care system in England is variations in access to care between (and sometimes within) different local authority areas. Despite welcome recent injections of funds, such as from the NHS settlement, the overall resources available to local councils for social care have not kept pace with growing demand, and most councils have raised eligibility criteria as a means of rationing. The definition of “highest needs” is largely determined by resource availability, and excludes many with substantial needs for personal care, practical help, social contact and psychological support. As a result people perceive the system of obtaining care and support as arbitrary and unfair.

5. Government guidance, set out in “Fair Access to Care Services”31 and its 2010 successor, aimed to address the consistency problem by offering councils a clear and transparent set of eligibility criteria to use when assessing people’s needs. But it sought to do this within a discretionary system whereby each authority could determine its overall funding for adult social care. As a result, councils under pressure have tended to raise their eligibility thresholds: this may have contained costs in the short-term, but at the expense of masking unmet need and possibly storing up higher costs.

6. The underlying principles of the “Fair Access to Care Services” (FACS) approach are sound: an emphasis on people’s needs rather than the limitations of a particular service, and a focus on outcomes, human rights and ensuring carers’ needs are taken into account. However, the implementation of the policy has resulted in unintended consequences, with a growing number of people effectively excluded from the social care system as their needs are not deemed high enough to qualify them for care or support.

7. A review of the guidance in 2008 by the former social care regulator, the Commission for Care Inspection (CSCI),32 examined the outcomes for people who do not meet local FACS criteria. CSCI found that councils made relatively little effort to follow up this group of people and record what happened to them. Since then councils have been encouraged to provide information and advice to all citizens.

8. CSCI made a number of criticisms of FACS including: lack of clarity and transparency in practice; lack of fairness in the way criteria are applied; continuing influence of service-led rather than needs-led approaches;
limitations of a risk/needs-based model that has led to inadequate and overly standardised assessments and neglect of some groups of people using services.

9. One of the consequences of tighter eligibility criteria is a rise in the number of people who are obliged to fund their own care, whether this is provided in a residential setting or in their own homes. Historical information on self-funders is sparse and there are significant regional and local variations. However, a study published earlier this year by the Putting People First Consortium, in conjunction with SCIE, looks at the circumstances in which people enter the care system, and makes the case for better information and advice for people on their options at a time of crisis.

10. The study found that entry into the care system almost always takes place in crisis situations, such as the loss of a spouse or a disabling fall: hardly any of the participants in the study felt they had chosen to accept care, or had been part of a genuine decision-making process. Pressure from hospitals for speedy discharge, and concern on the part of relatives about a person’s fitness and ability to manage at home, adds to the sense of emergency and the demand for decisions at short notice. Individuals and family members reported experiencing great difficulty in securing sound advice about service options, with local authorities often unable to give sound advice on the quality of independent sector provision, and the current regulator, the Care Quality Commission, focusing on compliance with essential standards and no longer offering a rating system for care services. Effective intervention and advice at such crisis points could increase people’s confidence, options and scope for decision-making, and reduce pressure on the care system.

11. Earlier intervention would avoid the situation that many people experience of being unable to access services until a crisis occurs. However, policy on prevention is not matched by levels of resource allocation. Whilst we know that preventative approaches, such as reablement services, can be cost-effective, pressure on resources in many local authority areas inevitably means waiting until people are at, or near, crisis point before intervening. In so doing, the health and wellbeing of family carers can also be put at risk.

12. Moreover, it appears that many people are diverted away from their local authority’s assessment process at an early stage. Revised guidance from the Department of Health in 2010 is clear that people are entitled to have their needs assessed and to receive advice on care options before means-testing is applied. But we know anecdotally that the practice persists of advising those above the capital limit that there is no point undergoing assessment, as they will clearly not qualify for publicly-funded help.

13. The Dilnot Commission recommended a “clearer, more objective eligibility framework”, with a single threshold and more consistent criteria. In a review of the existing legal framework for adult social care, the Law Commission also recommended simplifying the current approach to eligibility and assessment. Our view is that a new system should be based on a single national eligibility threshold for social care, with a fully transparent approach to assessment. Assessment should go beyond the functional activities of daily living and look at risks to independence and wellbeing more broadly, with the aim of supporting people to live as independently as possible and exercise choice and control in their lives. Assesment should also be consistent with other assessments in related areas, such as NHS continuing health care, disability benefits, and so on.

14. SCIE has commissioned some new work on several of these issues. It will look in particular at evidence from the experience of the NHS with continuing health care, where national eligibility criteria and tools were introduced to address questions of inconsistency. We will also look at evidence from comparable international experience on assessment and eligibility, at how best to support consistent professional practice, and at the separation of assessment and gatekeeping functions. Independent social work practices, which are currently being piloted under SCIE’s aegis, might offer a model for taking such a separation forward.

Promoting Personalisation

15. Personalisation, along with self-directed support, is integral to the transformation of adult social care. It is at the heart of a number of initiatives in different local authority areas designed to prevent people’s needs escalating, to enable them to move on from institutional settings, or to help them stay living in their own home. The use of personalised approaches to integrated adult social care and support can result in crisis prevention, thus avoiding admission to hospital or residential care, particularly for older people.

16. For disabled adults of working age, care and support should be addressed in the broader strategic context of independent living policies. This should enable people to access mainstream training, employment and housing opportunities, strengthening their position as citizens, securing their human and civil rights, and removing sources of discrimination and other obstacles to full social participation.

17. The “Think Local Act Personal” initiative reinforces personalisation as the way forward for adult social care. It emphasises that continued reform will be even more important during this period of financial
pressures, co-produced with service users and carers, with the aim of helping commissioners and providers find local solutions to the particular challenges they face in their area. Crucially, it represents a shift from government-led to sector-led improvement. SCIE is a key partner on the TLAP partnership and is involved in most of its workstreams. The TLAP partnership are about to publish “Markers of Progress” which set out in clear terms how people can tell if services and support are improving and meeting their needs.

18. One shortcoming of the present system is the dominance of three or four traditional forms of service provision—residential care with or without nursing support, home care, buildings-based day services—with too little interchange or flexibility between them. The result is a rigid service system, not easy to adapt quickly to the requirements of individuals and families, and lacking incentives for adaptation and innovation.

19. Personalisation and self-directed support emphasises greater choice and control for service users and carers over the services and support that are provided to them. It means putting the individual at the centre of the process of identifying their needs, and helping them make choices about how they are supported to live their lives. One of the most tangible aspects of this approach is personal budgets (including direct payments), which offer people who use services flexibility in identifying their preferred outcomes and in purchasing their own care and support. However, the emerging picture of progress with personal budgets in social care suggests that, although numbers of managed budgets are rising, the uptake of direct payments is not increasing greatly. The performance of local authorities in ensuring eligible people have choice and control through personal budgets remains very variable.39

20. There is evidence from studies both in the UK and internationally that the development of more personalised services can enable more effective use of limited resources.40,41 But systems and processes need to change, so that:

- Personal budgets are authentic and give people real choice and control. Whilst the numbers of PBs are rising rapidly, numbers of direct payments are lagging behind that rate of growth and it is such cash transfers which can really empower individuals;
- Everyone (regardless of their financial circumstances) has access to advice and information about how to maintain their independence;
- Efficient systems are in place for allocating and monitoring personal budgets; and
- Best use is made of resources and expertise in the community.

21. While it is too early to make conclusive, evidence-based decisions on whether personalisation strategies have delivered efficiency savings and reduced costs, recent evidence suggests that self-directed support and personal budgets could lead to improved outcomes for individual people for the same cost—if implemented efficiently and effectively. The personalisation agenda appears to be stimulating review and change in business processes, with the potential to generate efficiency savings and improve productivity. Work is, however, still needed on market development, diversification and community capacity-building so that personal budgets can be used as intended.

22. Access to independent support planning and brokerage is important for implementing personal budgets and direct payments for people who may not be confident about managing these, or who do not have support from carers, family or friends. User-led organisations are an important part of the support infrastructure, as they can also offer peer support and improve the uptake of personal budgets as direct payments.42,43

Integration between Health and Social Care: Effective and Efficient Care

23. Finding ways of making integration a reality between health and social care (and other services) is central to delivering improved outcomes for people who use services and their families. We know from research that effective, integrated, multi-agency working is key to maintaining the health and wellbeing of people with multiple, complex and long-term problems. But partnership working will need to extend beyond local government and the NHS, to include employment and training services, benefits systems, and private and commercial service providers.

24. In the context of an ageing population, with a growing number of people living with long-term conditions, better co-ordination and information sharing between acute, primary and community-based NHS staff and between health and social care and support services is crucial to achieving good outcomes for people and making best use of scarce resources. Preventing unnecessary hospital admissions and avoiding delayed transfers of care are better for individuals as well as for the system as a whole. It is important for health and social care to work closely with people needing support, and their families, to ensure that they get the most out of all available resources.

40 Personalisation, productivity and efficiency, Report 37, Social Care Institute for Excellence (2010).
41 Keeping personal budgets personal: learning from the experiences of older people, people with mental health problems and their carers. SCIE, February 2011.
42 Keeping personal budgets personal: learning from the experiences of older people, people with mental health problems and their carers. SCIE (February 2011).
25. SCIE’s work, for example on supporting black and minority ethnic older people’s mental wellbeing,\textsuperscript{44} shows that when health and social care work well together, people’s health and wellbeing improves. When health and social care fail to collaborate, people are burdened with closing the gaps for themselves—if they can. The ongoing divide between health and social care makes little sense to people using services.

26. The measure of successful “integration” should not be how perfect the process is, but how far it improves the lives of service users and carers. For some people, having a joint health and social care personal budget may be the best way forward. Integrating personal budgets between health and social care could add a new dynamic to the debate on integration by allowing service users and their families to commission health and social care services for themselves. It is a positive development that over recent months the Department of Health has been moving away from input measures and targets in a search to develop outcome measures. However, there are now three outcomes frameworks—for the NHS, public health and social care—which seems unlikely to assist the promotion of integrated working across these areas.

27. SCIE recently produced a briefing that sets out the ways in which working with adult social care can help clinical commissioning groups manage their new responsibilities, particularly around supporting people with long-term conditions affecting their physical and mental health.\textsuperscript{45} Developing new local relationships to improve the health and wellbeing of patients, as well as to achieve efficiencies, will be one of the key tasks of commissioning groups. Local authorities’ experience of commissioning social care may hold lessons that will ease the transition to becoming clinical commissioners and to developing health strategies to meet the health needs of the practice population, as well as the individual patient.

October 2011

Written evidence from Alzheimer’s Society (SC 09)

Alzheimer’s Society

Alzheimer’s Society is the leading care and research charity for people with Alzheimer’s disease and other forms of dementia, their families and carers. The Society has expertise in providing information and education for people with dementia, carers and professionals. It provides a helpline and support for people with dementia and carers, runs quality day and home care, as well as funding medical and scientific research. It campaigns for improved health and social services and greater public understanding of all aspects of dementia.

Summary

— Issues surrounding social care particularly concern people with dementia as they are some of the largest users of social care services.
— Alzheimer’s Society has campaigned for many years for a fairer system of charging for social care. Implementing the recommendations of the Commission on Charging for Care led by Andrew Dilnot could achieve this.
— There should be an open debate on areas where the additional funding needed for social care could come from, where no options are taken off the table.
— The needs of the person receiving care should be central to what is being considered when discussing social care, whether this discussion is on economic regulation, variation in access or quality.
— Alzheimer’s Society believes the forthcoming White Paper should address the funding and quality of social care as a priority.

1. Alzheimer’s Society Priorities for the White Paper

1.1 Alzheimer’s Society supports the findings of the Commission on Funding of Social Care and believes the White Paper should address the funding of social care. This issue has been kicked into the long grass too often, and in the White Paper the Government has a real opportunity to address the urgent need for reform and create a fairer system. For more information on our position with regards to the funding of social care, please see our response to the Commission on Funding Social Care, available on the Alzheimer’s Society website.

1.2 Alzheimer’s Society also believes that the White Paper has a role in addressing the quality of care. In addition, there is much that could be done in the period of time before there is legislation to improve the quality of care that people are receiving at the moment.

1.3 We also support the findings of the Law Commission. To see our submission to the Law Commission, please see the response on our website. We welcome the consolidation and simplification of the existing law. We also welcome the person centred approach which puts the needs and wellbeing of the individual at the centre of the statute and regulations which we feel will support the many people with dementia who may have needs relating to their condition, but who may not yet have a formal diagnosis. However, in addition the Society would like to see individuals who have identified needs, but who do not meet income criteria to be

\textsuperscript{44} Supporting black and minority ethnic older people’s mental wellbeing. SCIE report 38. (December 2010).

\textsuperscript{45} Social care and clinical commissioning for people with long-term conditions. At a glance 45, SCIE (September 2011).
given the same access to assessment and co-ordination of their care needs as those who are given Personal Budgets.

2. Funding

2.1 Alzheimer’s Society has campaigned for many years to end the unfair system of charging for social care which disproportionately affects people with dementia. As our report Dementia Tax\(^{46}\) found, people with dementia are likely to have high social care needs for a long time, meaning that they are means tested, and usually pay for all of the cost of this care, where the costs for other diseases are paid for by the NHS.

2.2 It also found that the impact of charging for care is felt across all socio-economic groups. 40% of people with dementia in care homes who were manual or service workers are paying over £300 per week. This is not just a “middle class” issue, but one that affects many people who have been on low incomes throughout their lives.

2.3 Dementia Tax 2011\(^\) report found that there was also very low awareness of financial products which insure against the cost of care, along with an enduring lack of awareness that social care is means tested and not included in general NHS care.

2.4 Alzheimer’s Society welcomes the report from the Commission on Funding Social Care, chaired by Andrew Dilnot. It provides the biggest opportunity in a generation to tackle the problem of funding social care. If the proposals were implemented they would make the system significantly fairer for people with dementia.

2.5 Alzheimer’s Society is also aware that while implementing the recommendations of the Commission on Funding of Social Care would create a fairer system, it will not improve the quality of care that already exists. A system which truly meets people’s needs would require funding additional to the £1.7 billion suggested by the Commission.

2.6 Given the current climate of public spending we understand that it is not automatic that the £1.7 billion that the Commission suggest is needed will be found. However, funding of social care is an issue that the Government cannot afford to ignore. Alzheimer’s Society believes that there should be a debate to consider which areas funding could be released from in order to fund a quality system of social care.

2.7 For example, the Commission suggested that those receiving NHS Continuing Care funding should pay for the costs of accommodation. Previous White Papers on Social Care have suggested that the Government could use funds currently used for Attendance Allowance to pay for social care. Age UK suggest a combination of National Insurance contributions, Income Tax and Pension tax relief could be used to fund social care.\(^{48}\) Alzheimer’s Society would like to see the Government properly examine each of these suggestions and many others in order to extensively explore all options.

3. Quality

3.1 Although the inquiry is not directly calling for evidence on quality, Alzheimer’s Society feels that quality of care is a key area of concern within the social care debate.

3.2 The quality of social care services for people with dementia is variable. While some providers deliver excellent care, in many cases the quality of care is poor. In previous consultations with people with dementia and carers, it was clear that they are happy to contribute to the cost of care as long as the quality is guaranteed.

3.4 It is important that there is a robust scheme of regulation for quality. As the Committee is aware due to its inquiry earlier this year,\(^{49}\) there are areas that the Care Quality Commission could improve the regulation of quality within the social care system.

3.5 There is also a need for increased training of the social care workforce. Up to two thirds of care home residents have dementia, yet very few care home staff have specific dementia training.

3.6 However, quality in care depends on many factors, including funding. Whilst it is possible to a certain extent improve quality through factors such as robust regulation, the amount of care that is needed to provide a quality system will depend on increased investment in the care sector.

3.7 Alzheimer’s Society believes it is important that any money allocated improve quality in social care is ring-fenced. There is clear precedent in ring-fenced funding from this Government. For example, the Government have ring-fenced funding to local authorities for public health responsibilities.

3.8 By contrast, there is a real danger that allocations where funding is not ring fenced cannot be accounted for. For example, the All Party Parliamentary Group on Dementia found that two-thirds of PCTs could not account for the funding allocated under the dementia strategy.\(^{50}\) In addition, Princess Royal Trust for Carers

\(^{46}\) Alzheimer’s Society, Dementia Tax, 2008
\(^{47}\) Alzheimer’s Society, Dementia Tax 2011, 2011
\(^{48}\) Care in Crisis: causes and solutions. Age UK, 2010
\(^{49}\) Commons Health Committee, Annual Accountability Hearing with the CQC, 2011
\(^{50}\) All-Party Parliamentary Group on Dementia, A Misspent Opportunity, 2010
and Carers UK found that where additional money was allocated for carers respite, this could also not be accounted for.

4. Variation in Access and Early Intervention

4.1 As the Committee is aware, different Local Authorities are at liberty to set the threshold of level of need at which it will begin paying for care. This leads to a “postcode lottery”, where people in one area may have their needs met by the Local Authority where in another they would not.

4.2 In consultations with our membership, they have told us that clear national criteria in eligibility and charging are more important to them than local flexibility. National consistency in the rules governing access to support would also increase clarity and make the system more acceptable to the public, which will help in terms of social sustainability.

4.3 In addition to variation in access, Alzheimer’s Society considers that access to social care services is too restricted. Many councils now only provide services to people with “severe” needs. A recent survey by the Association of Directors of Adult Social Services (ADASS) found that 4% of Councils provide services for people with Critical needs only and 78% of councils provide for people with Substantial needs and not for people assessed as having Moderate or Low needs.51 This obviously excludes many people in the early or middle stages of dementia from support and services which could help them have a higher quality of life for longer.

4.4 Earlier this year, the “Support. Stay. Save” report found that 50% of people with dementia in their own homes were not getting enough support and care to meet their needs.52 Lack of investment in community based services can also mean that someone moves into residential care more quickly than they would have done otherwise.

5. Economic Regulation

5.1 Recent circumstances with the care home provider Southern Cross has brought the economic regulation of the care to the fore. This left individual people with dementia and carers anxious about the status of their care.

5.2. Any economic regulation of care must primarily be concerned with the needs of the people receiving that care. The key priority should be that vulnerable people are not forced into compromised situations due to circumstances out of their control.

5.3 However, whilst the economic regulation in care is important, regulation of quality is a key priority, as discussed above.

6. Conclusions

6.1 Alzheimer’s Society believes that there are numerous areas which should be addressed by the Social Care white paper, including the funding of social care.

6.2 Alzheimer’s Society welcome the opportunity to discuss this further. I look forward to presenting evidence on 25 October.

October 2011

Written evidence from United for All Ages (SC 11)

OUR LEGACY TO THE FUTURE—CARE FOR ALL AGES

1. About United for All Ages

1.1 United for All Ages is a social enterprise bringing older and younger people together to create a stronger Britain. We work with local authorities, health trusts, housing associations and community organisations to promote shared sites, shared caring and shared interests across generations, and with policymakers, universities and think tanks to promote thinking for all ages.

1.2 United was founded in 2010 by Stephen Burke and Denise Burke who both have extensive experience in national and local organisations involved with care for older people, children, young people and families. Stephen Burke was chief executive of national charity Counsel and Care from 2005–10 and contributed significantly to the big care debate in 2008–10 and the debate around the Dilnot commission’s report.

1.3 United for All Ages is delighted to contribute to the Health Select Committee’s inquiry and would be pleased to expand on this evidence. The inquiry represents a real opportunity (as part of the care white paper process) to achieve long awaited, radical reform of the care system to deliver a better deal for all who need care, whatever their age, and their families.

51 Association of Directors of Adult Services, ADASS Budget Survey 2011. 2011
52 Alzheimer’s Society, Support Stay Save, 2011
2. The Case for Change—"Unfair, Underfunded and Unsustainable"

2.1 The reasons for reform of the care system have been well rehearsed. Quite simply, older and disabled people are being let down by the current system—care for many is either unaffordable or unavailable, with many people having to rely on family carers, make do within their own resources or struggle alone. Despite our ageing population, fewer and fewer older people are getting the help they need, with this unmet need growing rapidly. Increased gatekeeping is not only seen as unfair but is increasing the complexity of an already confusing system.

2.2 The postcode lottery—whereby what you get and what you pay depends on where you live—is perceived to be particularly unfair. This situation mirrors the experience of families seeking care for their children, with the cost of childcare prohibitive for many parents. Recent media coverage of the experience of parents with disabled children has also highlighted difficulties getting respite care and other support.

2.3 What has been less openly discussed are the consequences for families in Britain today. Clearly the current system is not sustainable in the face of our ageing population and growing demands for better care; but it is also not sustainable because of the impact on all families. We need a care system that is built to last for generations and a care system that serves all ages and doesn’t cause resentment across generations.

3. Families in Britain Today

3.1 Caring and paying for care are central to every family in Britain. But for too long, public policy has not reflected the multi-generational nature of family life in Britain today. Many families have four or five generations, with caring responsibilities for young children, disabled and older relatives. Care affects all generations, emotionally, physically and financially. More families are living in multi-generational households and more parents and grandparents report that they are “sandwiched” between providing childcare and eldercare.

3.2 United’s paper, United or divided?, published in January 2011, paints a picture of the impact on different generations—from the Forgotten Elders to the Sure Starters, with the Squeezed Midlifers sandwiched between older and younger generations. The current spending cuts to Sure Start children’s centres and to care for older and disabled people are squeezing families from all directions and creating intergenerational tensions. This makes it even more crucial that any solution to the “care crunch” focuses on the whole family and covers care throughout the life course. It must recognise and support the contribution made by family carers and the reciprocity of care within families.

3.3 Care is in crisis as families can’t get the care they need when they need it and at a price they can afford. As well as imposing huge social costs on families required to undertake caring themselves, this crisis has a massive economic impact as it prevents families from working and contributing to the wider society, and increases family poverty, ill health and despair. Far from empowering people, this care crisis is disempowering huge numbers of people and their families.

3.4 We need a new care system that is fair for all ages, simple and transparent to all, and sustainable for this and future generations. United’s paper, Investing in the Future, published in September 2011, looks at how wealth, work and welfare can be reconciled in a multi-generational society to help families to balance care with their other responsibilities.

4. The Dilnot Commission’s Recommendations

4.1 The Dilnot commission raised important questions about how to create a fairer and simpler care system for this and future generations of older people. But we believe its recommendations are fundamentally flawed.

4.2 Under the commission’s regressive proposals, the winners would be richer families whose inheritance would be relatively protected while most families would face a more confusing and potentially costly care system. The proposed cap on care costs would still result in some older people being forced to sell their homes to pay for care and related costs.

4.3 The proposals aim to reform the current inadequate system for funding care. But they would lead to a more complex, fragmented and confusing care system. Big questions surrounding the proposals include:

- the cap is regressive—everyone (except those below the proposed assets threshold) would be required to find the same amount of money regardless of their wealth. This could be seen as a care “poll tax” for the so-called squeezed middle;
- not many people have up to £50k liquid assets and therefore would be required to find it by selling their home and/or using their estate for a deferred payment or by taking out an insurance policy which again would cost the same regardless of income or wealth;
- encouraging people to take out insurance creates a whole new industry, increases the transaction costs (as in the USA) and creates more complexity and fragmentation (it also paves the way for increased use of insurance to pay for health); there is no evidence from anywhere in the world that a voluntary insurance scheme funding care actually works;
— what “care” costs would be included in the cap? Would it include the preventative help and support that enable an older person to stay independent (e.g., help with cleaning, shopping etc) or would it just be high level personal care? Would families have to make top-up payments to get the care they want, where they want it?

— the cap on “hotel” costs (e.g., accommodation, food etc) of residential care means someone in a care home for five or ten years with dementia, for example, would face a large bill of much more than £50k ie they could still lose their home. This would come to be seen as a big con; and

— the proposals also depend on the government committing to substantial extra spending on care—which is much needed but media reports suggest this may not be forthcoming. The Dilnot commission’s request for extra funding would simply help richer people pay for their care and would not address the unmet needs in the current system nor the growing demands of our ageing population.

4.4 Recent months have seen huge concerns about how care is delivered and funded. With the continued scrutiny of the Health and Social Care Bill, there is an important opportunity to consider how best to create a truly integrated health and care system that meets the needs of our ageing population. It is the only way to develop real care in the community and in people’s own homes while reducing expensive and inappropriate hospital and residential care for older people. The Dilnot proposals would not support integration but would perpetuate two separate systems.

5. A New Care System for All Families and All Ages

We therefore propose a new care system as follows.

5.1 What would a new care system offer and deliver?

— It would recognise the reality of family life in Britain today and serve and support people of all ages.

— It would offer support both to people who need care and to their families and carers, encouraging them to share the caring.

— It would empower people to live fulfilling lives and give people and their carers real choice and control over their care and support and their lives, building on the best of direct payments and personal budgets.

— It would offer a broad range of support from early intervention, practical support and help with living at home to intensive personal care.

— It would not depend on where people live, ending the postcode lottery.

5.2 What would be the key features of a new care system?

— It would be universal, with an entitlement to care funding for everyone on the basis of need, regardless of age or ability to pay.

— It would be fair and equitable, with people of similar needs treated equally regardless of the cause of their need for care or where they live.

— It would feature support for family and informal care as an integral part of the new system.

— It would have a strong national framework, led by central government, to ensure consistent eligibility criteria and quality of care across the country for all ages.

— It would be delivered through local authorities conducting assessments, supporting people and their carers to access care, and stimulating local provision of support.

— It would raise the status of care and caring, thereby helping to improve the quality of care.

— It would be based on the sharing of risks and the sharing of the costs of care.

5.3 Universality is key to ensuring buy-in from the whole population and to tackle the unpopular and fragmented local variations that currently exist. Universality is crucial to identifying a new way in which care for all ages would be funded. We support the Law Commission’s proposals, in particular for a national framework to challenge the postcode lottery.

5.4 United for All Ages calls for two major rationalisations promoting integration to make the most of limited resources:

— The creation of a national health and care service, bringing together responsibility for health and social care and reducing duplication and confusion; this would be facilitated by a new funding mechanism as set out below.

— The development of centres for all ages, shared sites whereby people of all ages could access the care and support they need in their local community, building on existing community services and resources.
5.5 How would a new care system be paid for?

The only way a universal care system could be funded is through compulsory contributions from citizens. Taxation and/or national insurance have long been seen as the best way to do this. However there are clear reasons why this would not be intergenerationally fair, given it would penalise those of working age and it would ignore the huge wealth that rests with people over the age of 50 in this country.

5.6 United for All Ages therefore calls for the Health Committee to re-visit the care duty proposal first set out by Philip Spiers. A percentage on estates above a certain value (for example, above £25,000 with the percentage ranging from 4–10% dependent on other public funding available) would be seen as fair because it would be related to wealth; it would end the unfairness of some people losing much or all of their estate to pay for care just because they happened to have dementia, for example; it would meet the growing costs of care and sustain provision of care for all ages for generations to come; and it would be seen as “our legacy to the future”.

5.7 It is our view that the care duty could fund a care system that would be fair, simple and sustainable. It could provide care free at the point of delivery under NHS principles as part of a new national health and care system.

6. Making Change Happen and Managing Transition

6.1 In the context of economic retrenchment, the proposals above may seem ambitious. However in the grand scheme of public spending, the sums involved are relatively small and making the change is very “doable”. The forthcoming care white paper could achieve long-lasting and substantial reform that delivers better care for all. It is time for boldness and leadership.

6.2 Clearly the public and politicians need to be persuaded of the case for change and the benefits of the proposed reforms. Intergenerational fairness will be one of the key measures of any proposal and its likely longevity. We will all have to pay more for better care; it therefore makes sense to choose an option like the care duty which shares the cost fairly for generations to come.

6.3 In the interim before the white paper’s proposals are taken forward and enacted, people of all ages and their families face rapidly retreating care provision as public spending cuts bite. It is therefore crucial that people and their families are helped to get the best care by:

— Providing information and advice, particularly specialist financial advice.
— Ensuring deferred payments operate effectively in all local authorities.
— Implementing the Dilnot Commission’s recommendation on raising the assets threshold to £100k with immediate effect.
— Encouraging local authorities to support early intervention and practical help in the home.
— Setting up a prevention foundation, using the early intervention foundation for children and families as a model, to promote evidence-based practice and seed-fund prevention.
— Integrating health and care through pooled budgets or a single budget.
— Maximising resources by sharing sites for all ages.
— Supporting family carers of people of all ages.

October 2011

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Introduction

Age UK is pleased to be able to comment on the Government’s plans for social care reform in England.

We commend the Government’s vision for social care outlined in November 2010. We welcome the publication of the Dilnot Commission report, Law Commission report and the Government’s commitment to produce a White Paper on social care reform by April 2012.

Reform of social care is urgent. There is a real danger that social care will get worse not better as a result of recent cuts in older people’s social care services. Age UK analysis of DCLG data shows that social care spend on older people decreased by 6.4% in 2010–11. Meanwhile demand for services is predicted to increase as those most likely to need care and support, those over 85, rises. Action is needed now to ensure that the social care system is radically reformed and that services are available for those who rely on them.

Age UK has identified eight key components which must be built into the reform plans if they are to be successful.

1. Implement the full package of funding reform as proposed by Andrew Dilnot, to include the capped-cost model at £35,000 as well as increasing the means-test for residential care to £100,000.
2. Protect existing spending for social care to ensure that the current care system is not further undermined. This can be achieved by rigorous control of social care spend by the NHS, and stronger reinforcement of Government expectations that funding allocated for social care reaches front line services.
3. Fully implement the Law Commission proposals so that individual rights and entitlements are strengthened. This should specifically include safeguarding legislation and carers’ rights to services.
4. Introduce a national eligibility threshold to be used in every English Local Authority. We encourage Government to set this at moderate, but recognise that on implementing reform a starting threshold of substantial may be more practical. We would like Government to commit to expanding availability of services to moderate and set a timetable for this.
5. Build in a range of mechanisms to ensure quality is maintained and promoted. These should include, in addition to giving people greater consumer power through personal budgets, improved regulation of service provision and greater support for user voice and choice.
6. Regulators and commissioners should have stronger responsibilities to ensure continuity of care and a stable “mixed market” of care provision.
7. Health and wellbeing boards should co-ordinate a strong system of preventative and low-level support so that these services are a joint responsibility between the NHS and social care.
8. A national network of information and advice providers, building on existing provision, should be supported by the Government. Individuals should be able to access timely information, advocacy and advice in every area in the country.

(1) The practical and policy implications of the Government’s plans for funding social care, and the recommendations made by the Dilnot Commission and the Law Commission

Funding

Age UK is concerned about the apparent separation of funding reform and service reform within the planned White Paper. It is impossible to address the issue of reform without understanding what is being paid for as well as how it will be paid for. The Department of Health engagement process focuses entirely on service delivery and quality issues, with funding reform the subject of an additional paper published alongside the White Paper. Separating the two elements of reform in this way is a missed opportunity to deliver radical change in a joined up way. We are urging the Government to design a single new system, where adequate care funding streams support high quality service delivery.

Age UK supports the package of funding proposals as set out by the Dilnot Commission. We believe the proposals would deliver a social care funding system where individual responsibility is clear and understandable, enabling people to plan ahead, and where the state support is definable and sustainable. In particular, Age UK supports the principle that catastrophic costs of care should remain the responsibility of the state.

In reforming social care funding the Government should also be mindful of the following:

— Existing services urgently need funding to ensure that future reform has solid foundations.
— Reform should strengthen and not weaken any additional rights to care and support.
— Services should be available more widely than at present, for example, to people who have moderate or substantial needs and above.
— Reform will cost money. However, this does not all need to be state-provided. Where additional payments are required from individuals there should be a clear offer showing what people are entitled to.

The Law Commission review

A clear and consistent legislative framework is vital if older people and carers are to be able to speak out and challenge inadequate care, and needs to be supported by good information about entitlements and by good advocacy services. Age UK supports the full implementation of these proposals.

We support proposals for principles to underpin social care, including the overarching “wellbeing” principle. Making the purpose of social care clearer will help challenge assumptions that care for people aged over 65 can be less ambitious in its objectives than for those aged under 65.

Proposals for safeguarding legislation are particularly welcome. Safeguarding adults at risk of abuse is not just a social care issue so there may be a need for further legislation to strengthen and clarify the roles of other agencies such as the NHS and the Police.

(2) The scale and implications of existing variation in access to and charges for social care in England

Access

Access to care services is increasingly restricted leaving older people without basic support. In 2011 an ADASS survey showed that 78% of councils met need at substantial or above compared to 70% in 2011–12 (this compares with 53% in 2006–07). Between 2010–11 and 2011–12, 15 councils moved from moderate to substantial. King’s Fund data shows that there are currently 800,000 older people who have care needs which are not met by state provision of support.53

Some Local Authorities are also misinterpreting statutory guidance that requires consideration of a wide range of risks to independence when undertaking an assessment. These risks relate to wellbeing and quality of life as well as physical needs. Age UK is increasingly concerned that some local authorities are not adopting this approach, by restricting services only to people who have personal care needs.54 Such approaches downgrade the essentials of a meaningful quality of life simply to safe physical functioning. This has the potential to create a culture in which the aim of care is seen as little more than warehousing of older people.

Councils are also seeking to restrict provision of services by adopting a narrow definition of need. In one case a local authority has consulted on a move to meeting “critical” needs only, but also substantial needs where they are likely to become critical. Predictions of the likelihood of care or safeguarding needs occurring are also being used, for example, someone for whom life is or will be threatened does not qualify for statutory services if the likelihood is regarded as “unlikely”—but unlikely is defined as a 40% chance of something happening within six weeks.

To create more consistency and allow less room for interpretation of care needs, Age UK is calling for a legislative definition of a minimum level of care services to be included within the White Paper and subsequent legislation. This was proposed by both the Law Commission and Dilnot Commission. The national minimum should be set at substantial initially, but we support the Dilnot Commission proposal that this should be widened post-reform. The minimum should be defined in terms of outcomes achieved by the individual in receipt of services taking into account safety, recovery from major life changes, participating in social, community and family life, and to retain and recover the essential elements of their identity as individuals.

Funding preventative services should be a priority built into plans for reform. Funding streams for preventative services should be part of health and social care budgets and providers should work together to commission jointly where appropriate and share joint objectives. Budgeting for preventative services should be more flexible so that financial benefits gained over the medium to long term can be supported. Prevention should be seen as an issue that goes beyond social care—it should include “big society” approaches to increase community support, more accessible housing, services and transport, and increased NHS funding.

Even where services are available understanding and obtaining care is difficult, particular where there are cognitive or communication difficulties, in an emergency or upon discharge from hospital. People are often reluctant to approach services as they are concerned that choice will be taken out of their hands and they will end up in residential care. It is therefore important that advice, assistance, and advocacy, delivered at a one to one personal level, and independent of the local authority, is available. Personal budgets make this even more important.

Many older people will not want to arrange their own care, but for those who do support must be available. Older people have particular requirements for support to use direct payments.

53 Securing good care for older people, King’s Fund, 2010.
54 In one case a local authority consulted on proposals to restrict eligibility to people whose needs were judged as “critical” and to restrict care to personal care needs only. Two local authorities have proposed that care should be restricted to people who are “critical” and “substantial” only if there is risk to their safety.
Charges

There have, during the last two financial years, been widespread increases in charges for care services. Of particular concern is the financial impact of the widespread removal of maximum charges during 2010–11, resulting in sudden and sometimes huge fee rises for people who receive large packages of care. A 2011 Community Care survey found widespread evidence of this.55

Where local authorities are charging for the full cost of providing services it is not transparent how those costs are being calculated.

(3) The practical and policy implications of the Government’s commitment to promote personalisation of social care, including personal budgets and direct payments

The Department of Health has confirmed its support for personalisation in social care.56 Age UK has fully welcomed this as all service users value choice and control over their services. However, the Vision statement does, in some areas, equate personalisation with personal budgets. Personalisation must involve a broader range of approaches than personal budgets. Personalised services should be universally available regardless of the type of care provided or the setting for the care. For example, older people in care homes should receive a personalised service where they are supported to have choice and control.

For many older people, particularly those who have extremely high or fluctuating needs, managing and arranging the delivery of services themselves is very difficult. No service user should be forced to receive their personal budget as a cash payment if they do not wish to do this. People should have a genuine choice of having the local authority arrange services on their behalf.

In 2008 the Commission for Social Care Inspection raised concerns that the Resource Allocation System used by many councils was not transparent, did not allow for equity between different types of service user, and limited the support available to older people with more complex needs.57 There is no evidence that the situation has improved. The level of personal budget must be directly related to someone’s assessed needs and must be adequate to obtain support to meet those needs.

Recent research carried out at the University of Exeter found that all systems surveyed lacked transparency and in one case it was the local authority’s policy to keep the method of calculation secret.58 This can result in an inability to purchase the required care, or in the necessity of a top up. There must continue to be an individualised system of assessment which results in a clear statement of the needs the local authority has agreed to meet and the support that it agrees to provide to meet those needs.

(4) The barriers faced by recipients of social care when they wish to relocate to another area, particularly with regard to the portability of assessments

Age UK supports proposals made by both the Dilnot and Law Commissions to make assessments portable and to enable people with care and support needs to move between local authorities. We have found the 2010 Ordinary residence guidance to be extremely useful in resolving disputes between local authorities as it makes clear that authorities should co-operate and that a person who wishes to move should not be disadvantaged as a result of disputes between local authorities. This guidance might be a basis for legislation to meet the recommendations of the Law Commission.

(5) Economic regulation of the social care system including a proportionate failure regime that can mitigate against the failure of social care providers

We welcome the Committee’s recognition of the need to mitigate against the failure of care providers. This represents an advance on the Government’s position set out in the Health and Social Care Bill, that an economic regulator should have powers to take action in the event of service failure but has no part to play in preventing such failure. Indeed the market shaping role proposed for Monitor in the current bill is limited to stimulating and increasing competition.

We welcome Department of Health discussion paper Oversight of the Social Care Market, and that DH is now looking at prevention of service failure as well as responding to it.

The need to prevent service failure and to have contingency plans in place has become a subject of public concern as a result of the collapse of the Southern Cross care home chain. However whilst the failure of a large provider would create considerable difficulties for local authorities so might failure of a single operator. Research by the University of Birmingham59 shows closing a care home properly takes a minimum of six months. Registration requirements and contracts with homes, including those made by local authorities, should therefore require six months notice of closure or de-registration.

55 www.communitycare.co.uk/Articles/24/01/2011/116164/councils-press-on-with-home-care-charges-increase.htm
59 Ion Glissy et al—Achieving Closure; Good Practice in Supporting Older People During Residential Closures—University of Birmingham/ADASS June 2011.
This would mean that providers would have to be sufficiently financially viable to operate for a six month period. There are three possible approaches to ensuring that a provider could meet his requirement:

- Insurance could be held: this, however, might be unrealistically expensive, particularly if, as we have argued above, contractual notice periods need to be much longer than at present.

- Regulators might require that providers demonstrate financial viability. However this is difficult in an industry where, as investigations by the GMB Union have shown, providers are often part of complex organisations located across the globe, including in secretive tax havens.

- Commissioners might similarly require providers to demonstrate financial viability. In many cases local authorities will have considerable experience of making such inquiries for large contracts in order to satisfy contract standing orders. The same problems would arise, however, as would the case if regulators required this information. If it were left to local authorities to require assurance of financial viability it would not necessarily benefit self funders, so we would regard a regulatory approach.

One way around these difficulties might be a hybrid system whereby regulators or commissioners required evidence of future financial viability and if they were unable to obtain this to their satisfaction due to the complexity of the provider’s financial structures they could then require the provider to hold appropriate insurance. This would disadvantage providers with opaque financial structures, but it is arguable that this would be legitimate as being in the interests of both the consumer and the taxpayer.

(6) *The practical and policy implications of the Government’s stated commitment to promote integration between health and social care services*

Care and support for older people should be better integrated, not only between the NHS and social care, but between social care and other local services such as housing.

The Government has frequently stated that integration, both between NHS services and between health and social care, is a priority for reform. This was reiterated in the June 2011 NHS Future Forum report. The Health and Social Care Bill encourages a greater degree of checks and balances between health and social care commissioners. However, there is little indication in this or accompanying policy documents that the overarching framework will deliver the integration that is required.

For example, the joint health and wellbeing strategies will inform priority-setting for both the Local Authority, through the Health and Wellbeing Board (HWB), and Clinical Commissioning Groups (CCGs). Each body will then have limited sign-off of their respective plans. However, there is little to suggest that either the HWBs or the CCGs will be able to enforce the joint strategy.

This suggests that the Government understands that joint objectives work. We are concerned, however, that without a firm statutory footing success is reliant solely on strong and motivated leadership. In the face of competing priorities and in particular the pressure on CCGs to meet requirements under QIPP (which does not cover social care), integration is at risk of being an additional rather than fundamental aspect of service planning.

There are a number of fundamental barriers to integration of health and social care:

- NHS support for long term conditions has not made the same progress in implementing personalisation and choice as social care services. An example is choice of accommodation for people who need residential care services—people funded by a local authority have a statutory entitlement to choice whereas people funded by the NHS may be given no choice. Greater integration should not result in reduced personalisation.

- NHS services are free at the point of use whereas social care is means tested. For this reason, as well as in order to ensure clarity around accountability, people need to know whether services are NHS or social care services.

- NHS care is often provided on the basis of long term care pathways which enable consideration of expenditure over the course of a long term condition so promote an approach which seeks to make future savings through prevention and reablement. Funding of local authorities to provide care and support should enable a similar long term approach.

When considering integration of services, the Government must consider the effect of social care provision on demand for NHS services. Taking this approach would also benefit the NHS in its response to the “Nicholson challenge” but it is currently not a focus. Reducing demand for NHS services by investing in community preventative and reablement support would create financial saving.

The Government should therefore prioritise areas of care that can have an immediate effect on better integrated care. Avoidable admissions to hospital, for example, would return dividends both in terms of improved patient experience and a reduction in expensive hospital bed days. Age UK welcomes Government initiatives seeking to tackle this issue such as reduced payments for readmissions within 30 days. However, this does not sufficiently focus on the role of social care in this process focusing solutions such as the discharge
tariff on health providers. Targeted changes now will help to lay a firmer foundation for more fundamental changes later on.

October 2011

Written evidence from The King’s Fund (SC 19)

1. The King’s Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

Summary

2. This submission focuses on the key issues emerging from our recent work on social care spending and the NHS, the Dilnot Commission and the integration of health and social care. In summary:

   — The need to secure a sustainable funding settlement for social care has never been more urgent, with local government and NHS finances under significant pressure and demand for services increasing as the population ages. The NHS will never work properly without a sustainable approach to social care funding.

   — The Dilnot report offers a credible and costed way forward—the government must move quickly to undertake detailed work on its recommendations and honour its pledge to publish a White Paper followed by legislation in 2012. There are some “quick wins” that would not involve substantial additional expenditure.

   — The adoption of the capped cost framework recommended by Dilnot offers a fairer and more transparent way of sharing the costs of care in a partnership between the individual and state. This will make it easier to tackle the deeper problem of under-funding that has led to tighter rationing of services and escalating levels of unmet need.

   — Arrangements for the economic regulation of adult social care to ensure continuity of care in the event of business failure should be reviewed in the light of the Southern Cross experience—a number of options should be considered to achieve a proportionate and risk-based approach.

   — Integrated care, based on stronger collaboration among professionals and better co-ordination between services, offers the most promising approach to improving care and meeting the key financial and demographic pressures facing both the local government and the NHS. However, progress so far in integrating health and social care has been patchy, despite emerging evidence that it offers significant opportunities to deliver better outcomes and financial savings. It is essential that the NHS and local authorities do more to pool resources and align services locally.

   — In the longer term, there is a compelling case for considering how the combined public expenditure on the NHS and social care in excess of £121 billion could be better planned and allocated.

The Government’s Plans for Funding Social Care

3. The squeeze on local authority budgets over the next four years will see a widening gap between needs and resources. As we indicated in our evidence to the Committee’s previous inquiry into public expenditure, despite the additional £2 billion announced in the Spending Review and the best intentions of local authorities to protect social care, a funding gap of at least £1.2 billion could open up by 2014 unless all councils can achieve unprecedented efficiency savings. Since then, the ADASS budget survey shows that there will be almost £1 billion less in adult social services budgets this year, of which councils aim to recover £681 million from efficiency savings. This is a very ambitious target when taking account of efficiencies already achieved in recent years.

4. The King’s Fund welcomes the Dilnot report. While further work is required on the detail, it offers the prospect of a lasting settlement based on a partnership approach in which costs are shared between the individual and the state in an open and transparent way—a principle we have long argued for. The need to secure a sustainable long-term funding settlement for social care has never been more urgent, so it is disappointing that the timetable appears to have slipped. The government must move quickly to bring together its response to the Dilnot report and the Law Commission Review of Adult Social Care Law into a single wide-ranging plan for the reform of social care funding and delivery and ensure there is no further delay in honouring its pledge to publish a white paper followed by legislation in 2012.

5. The proposals to cap individual liability for the costs of care and to raise the upper threshold for the means test would represent a substantial improvement on the current system and ensure that people in every income group are better off. This would avoid placing disproportionate costs on the taxpayer, compared to the costs of providing free personal care, while protecting people from the worst excesses of the current system and the cliff-edge of the present means-testing arrangements. Raising the upper threshold of the means test to £100,000 would involve a relatively modest cost of £100 million. These changes would particularly benefit
those on modest incomes, who are heavily penalised under the current system. The level of the contribution to
general living costs—suggested at between £7,000 and £10,000 a year—and how this is balanced with the level
of the cap will also be important in determining the cost of the proposals and the affordability to individuals.

6. The additional costs of implementing this capped cost model—£1.7 billion, rising to £3.6 billion by
2025–26—relate to the additional costs of implementing the new proposals only. The Commission
acknowledges that the current system is underfunded and has not kept pace with demographic changes in
relation to working age adults and older people. The overall level of resources required by the current system
was outside the Commission’s terms of reference, but the report makes clear that in addition to funding for the
new proposals, “additional public funding for the means-tested system” will also be needed. Unless this is
addressed, many of the well-chronicled problems with the current system will continue, including escalating
levels of unmet need and underinvestment in preventive support. The Commission’s view is that until the
current assessment system is replaced entitlement to local authority funded services should be set at
“substantial” or above under the current Fair Access to Care Services (FACS) criteria.

7. While we welcome the proposal that eligibility for social care should be set nationally, replacing the
FACS criteria with a new assessment measure may create difficulties in reconciling a new national “offer” with
the realities of wide variations in spending and resource levels across 152 local authorities. Having a portable
assessment may not entitle someone to the same level of service should they move to another local authority
area.

8. The profound difficulties of identifying new resources in the current economic and fiscal climate are
recognised and this supports the recommendation of our 2010 review for a staged, long term approach to
reform. However, the level of additional resources—both to implement Dilnot and to tackle unmet need—
should be viewed against overall public spending on older people of £140 billion and total public spending of
just under £700 billion—and would amount to around 0.5% of GDP. The recent decision of the government to
find—apparently outside of the spending review—£1 billion for weekly council refuse collections and to freeze
council tax—is a reminder that the primary issue is one of relative political priorities rather than absolute
affordability.

9. In view of current concerns about the wider economy and the implications for public finances, it is timely
to emphasise the economic case for investment in social care. Public spending on this area current represents
1.2% of GDP, the majority of which is expended through wages and salaries of the 1.5 million people who
work in a sector that is not characterised by high levels of pay. Any additional investment therefore could
create a significant multiplier effect. Further economic benefits could be expected from better social care
support for carers and for people with disabilities that would increase the likelihood of retaining employment.

10. The proposal to cap individual liability for care costs would significantly ease boundary disputes between
means-tested social care and NHS continuing health care, which is free at the point of use. The Dilnot report
recognises that the assessment process for continuing care will need to be reviewed in light of the proposed
national eligibility framework for social care, and how the proposed new, more objective assessment tool for
social care would operate alongside existing assessment processes for continuing care. The Commission
strongly supports the Law Commission’s recommendation to put NHS continuing health care on a stronger
statutory footing.

11. There are some immediate steps that could be taken without requiring substantial additional resources.
These include: the raising of the upper threshold of the means test for residential care to £100,000; the
introduction of a universal deferred payment scheme that would help detoxify the issue of people selling their
homes to pay for care; and work to develop comprehensive information and advice services to everyone with
care and support needs and not just those entitled to publicly funded services.

Economic Regulation of the Social Care System

12. The recent case of Southern Cross has highlighted the need to consider whether existing arrangements
to ensure continuity of care are adequate. Already over 75% of adult social care provision is provided by at
least 40,000 private and independent providers. This care is commissioned by local authorities; private
individuals with their own funds or with direct payments and by primary care trusts. It is a relatively stable
business sector, with approximately 17,500 care homes, of which it is estimated that just 175 were de-registered

13. A specific objective of government policy is to promote a dynamic, pluralistic market that responds
innovatively to individual needs. Those that struggle to achieve this or offer poor quality care will be displaced
by new providers. A degree of turnover is inevitable and thus arrangements should be in place to protect threats
to individual care arrangements that arise from business failure as well as failure to meet care standards.

14. The characteristics and context of the adult social care market represent are fundamentally different to
the NHS, so a model of economic regulation based on the proposed role of Monitor for any qualified providers
in health care may not be appropriate. Existing arrangements for the closure of individual care homes generally
appear to work well, with the local authority working collaboratively with the CQC and other providers to
ensure that no-one is left without the care they need. This suggests that the focus of any new arrangements
should be risk-based and proportionate, for example applying to providers who exceed a certain size or market share, especially where these transcend local authority boundaries.

15. A range of additional measures could be considered including strengthening the existing powers of CQC to assess and monitor business viability; developing the role of local authority commissioners in assessing the financial resilience of potential providers; a clearer role for local authorities in overseeing their local market, perhaps in collaboration with the regulator; better money advice for individuals who self-fund their own care; and/or the development of a national protocol that sets out the respective roles and responsibilities of the Department of Health, local authorities, the regulator, and the care industry. This could draw on the lessons learnt in managing the consequences of Southern Cross.

The Integration of Health and Social Care

16. Integrated care has been a recurrent goal of public policy under successive governments for more than 40 years. The Dilnot Commission called for improved integration of health and social care in order to deliver better outcomes for individuals and value for money for the state. We agree that the integration of health and social care is central to meeting the challenges faced by the NHS and social care systems and have set out the inter-dependency of the two systems in more detail elsewhere (Humphries, 2011).

17. Integration can take different forms and at different levels. Our recent assessment of the national and international evidence concluded there is no “one” best way of delivering integrated care. Structural or organisational routes to integration will not deliver benefits unless preceded by other changes such as new ways of working and clinical or service integration. There are some good examples in the area of care for older people, for example, analysis of Torbay’s Integrated Care Project (Thistlethwaite 2011) has highlighted low rates of emergency admissions, emergency bed day use and discharges into residential care compared with other areas in the South West.

18. Successful examples remain isolated, and there are wide variations in progress and performance from one place to another. For a variety of reasons local examples of success have not been replicated at scale throughout the country, with less than 5% of NHS and social care budgets are subject to joint arrangements. A more ambitious approach is required. This should avoid an over-prescription by central government, with the emphasis instead on developing financial, performance and outcome frameworks that create incentives to integrate care.

19. More attention could be focused on aligning the total spend across the NHS and social care—now in excess of £120 billion—around the needs of patients and service users through mechanisms such as joint agreements, pooled budgets and place-based approaches (including work begun under the “Total Place” programme). The identification in the Spending Review of £1 billion within the NHS budget for beneficial spending on social care is a welcome first step and should encourage interest from NHS commissioners in the benefits to the NHS of different kinds of investment in social care services.

20. We welcome the amendments that have been made to the Health and Social Care Bill to promote integration. The proposed duty for clinical commissioning groups (CCGs) to promote integrated care provides an opportunity for local initiatives to be clinically driven. It will be important for CCGs and local authorities to work in partnership through local health and wellbeing boards. The proposed health and wellbeing strategies and enhanced joint strategic needs assessments offer a mechanism by which the commissioning and planning of services can be better coordinated across health and local government boundaries. Our work with local authorities and their partners suggests the emergence of new conversations and relationships between GPs and local government. The government has indicated that CCG boundaries should not now cross those of local authorities, unless this can be justified in terms of benefits to patients. This is a positive development—co-terminosity is an important factor in aligning plans and resources.

21. However, these opportunities may be undermined by other consequences of the NHS reforms. There is clear evidence that the key to delivering integration is stable leadership and time to allow for the evolution of vision and trust between local partners. We are concerned that this will be disrupted by the complex organisational changes set in train by the changes. For example, the advent of clinical commissioning groups and the move to PCT clusters potentially threatens the shared management arrangements which have developed between some local authorities and PCTs.

22. The NHS Future Forum argued that “we need to move beyond arguing for integration ... to making it happen” and this has become part of the next stage of its work. To support this, The King’s Fund is working with the Nuffield Trust to help develop a national strategy for the promotion of integrated care at scale and pace in local communities. The joint project will:

- Identify ways to overcome barriers to integrated care, which can include current NHS policy and management rules and practices;
- Support the development of integrated care at a large scale and at pace;
- Test ideas with health and social care professionals at the front line; and
- Analyse the published evidence about what works in delivering integrated care, including the policy and management characteristics of successful examples.
The findings from this work will be submitted to the Department of Health and the NHS Future Forum, and we would be happy to share them with the Committee.

References


October 2011

Written evidence from the Audit Commission (SC 24)

Summary

1. The Audit Commission welcomes the opportunity to submit evidence to the Health Committee’s inquiry into social care. Our response focuses on three points in the terms of reference.

Existing Variation in Access to and Charges for Social Care in England (see Section 1 of this Submission)

— Council policy on eligibility has only a very modest effect on expenditure, and the overall volume of care funded for older people has reduced since 2005–06, despite the ageing population.
— There are significant differences in care costs across England. Some councils spend three times more than the average, per person, on some services.
— 6% of councils increased charges to people in 2009–10.

Personalisation of Social Care, including Personal Budgets (Section 2)

— Self-directed support can offer increased choice and control, as well as having a positive impact on health and wellbeing.
— Personal budgets are unlikely to result in significant cost savings for councils. Better value comes mostly from improved outcomes, not savings.
— Councils will have to reconsider their roles and relationships in response to the increased use of personal budgets.
— Councils should review their financial and information systems to improve budget monitoring, recording of personal budgetholders’ spending and outcome recording.

Integration between Health and Social Care Services (Section 3)

— Integrated working across health and social care offers potential both for efficiency savings and improving outcomes for people.
— The extent of joint working varies across the country.
— As financial constraints increase, there is a danger that both the NHS and councils will focus solely within their own organisations to make savings.
— Integration arrangements can be complex, and not all bodies understand the available options.
— Clear leadership is vital to engage staff with the new integrated ways of working.

Detailed Response

SECTION 1: THE SCALE AND IMPLICATIONS OF EXISTING VARIATION IN ACCESS TO AND CHARGES FOR SOCIAL CARE IN ENGLAND

2. The Commission has published research that explores variation in:

(a) eligibility criteria, and how this affects access to services;
(b) spending on services, for those who satisfy the criteria; and
(c) charges, for those who pay for services.

(a) Eligibility criteria

3. There are differences in expenditure between authorities applying different eligibility criteria. In 2006–07, those authorities applying a lower “moderate” threshold spent more per older person: on average 5% per older person in the population more than those with the more restrictive “substantial” threshold. Total gross expenditure per older person in the population was £1,274 in “moderate” areas and £1,212 in “substantial” ones (Ref 1).
4. Home care per older person is the largest single contributor to this effect. “Moderate” authorities supply more non-intensive home care services than “substantial” authorities (45.4 clients per thousand older people compared to 39.6 in 2006–07).

5. A more restrictive policy is therefore associated with a consistent decrease in total expenditure per older person, although the effect is small when compared with the overall variation in expenditure between authorities. There is a link between spending on older people and the relative level of deprivation of the authority. However, the highest spending authorities spent three times as much per head as the lowest in 2006–07, even after allowing for deprivation. Differences amounting to several hundred pounds per head are not uncommon (figure 1). Despite the wide variations in spending on social care by local authorities, it is not known what impact this has on NHS expenditure.60

Figure 1

GROSS TOTAL EXPENDITURE PER OLDER PERSON AND DEPRIVATION

![Graph showing gross total expenditure per older person and deprivation](image)

Source: CIPFA 2006–07; Index of Multiple Deprivation 2007 (ONS)

6. Council policy on eligibility therefore has only a very modest effect on expenditure, and tightening of FACS bands is not a powerful means of controlling costs. This may be partly because guidance on the application of the bands allows for large differences of interpretation between authorities.

7. More recent research by the Commission found that productivity fell between 2005–06 and 2009–10. For older people, activity levels fell while costs remained broadly steady in real terms at around £9.4 billion (Ref 2). The fall in activity for older people does not appear to be a result of councils tightening the FACS eligibility criteria threshold, as this has changed little over the four year period (figure 2).

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60 This may be an area that it ripe for analysis in future, as Derek Wanless noted. The Nuffield Trust is undertaking some work into predicting social care costs.
8. Possible reasons why care funded by councils did not increase include:
   — Councils have applied existing eligibility criteria more tightly to concentrate services on the people with the highest needs, providing more intensive (and expensive) packages of care.
   — Financial assessments have become more rigorous, resulting in councils needing to support fewer people.

9. With personal budgets, councils allocate indicative budgets according to their assessment of need. These often adopt a “pounds per [need] point” system. Councils often use a linear system in which each point awarded in the needs assessment receives the same allocation. Some use a stepped system where points at higher levels of need receive a greater allocation. However, councils have different viewpoints on price points, and the number of pounds awarded per point varies (figure 3). This may affect portability, as some councils may not honour allocations awarded elsewhere. We recommend that each council’s indicative resource allocation system should be made publicly available.
(b) Spending on services

10. There are significant differences in the average weekly or daily spend on care services among councils. Some councils spend three times more than the average per person on some services (Table 1) (Ref 3).

<table>
<thead>
<tr>
<th>Table 1</th>
<th>AVERAGE GROSS WEEKLY EXPENDITURE—2007–08</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ratio of maximum to average</td>
</tr>
<tr>
<td>Meals per older person receiving them</td>
<td>3.0</td>
</tr>
<tr>
<td>Direct payments per older person receiving direct payments</td>
<td>2.5</td>
</tr>
<tr>
<td>Supporting older people in residential care provided by council</td>
<td>2.5</td>
</tr>
<tr>
<td>Home care per older person receiving home care</td>
<td>2.0</td>
</tr>
<tr>
<td>Supporting older people in residential care provided by others (per person)</td>
<td>1.5</td>
</tr>
<tr>
<td>Average gross expenditure per day care session for older people</td>
<td>2.5</td>
</tr>
</tbody>
</table>

*Source: NHS Information Centre 2009, Audit Commission*

11. On average, councils spent just over half (£0.52 in the pound) of their older people’s budget on residential and nursing care in 2009–10 (Ref 2). But there are important variations among councils (figure 4). The different rates of spending reflect significant differences in the use of residential and nursing care by authorities.
12. 42% of councils reported making efforts to shift care from residential care homes to community-based settings, with the real terms cost of residential and nursing care falling by 10% between 2005–06 and 2009–10 (figure 5).
(c) Charges

13. While we have no data on variation in charges, our research has shown that 6% of councils increased charges to people in 2009–10 (Ref 2). 13% of councils reported savings through making changes to their charging policy and processes.

14. Overall, people are less tolerant of charges that relate to those services they need, such as social care services, rather than those they choose to use, such as leisure services (Ref 4).

Councils apply national guidance for charging for residential care under the Charging for Residential Accommodation Guidance. However, the cost of domiciliary services for charging purposes is calculated depending on the policy of the local council and the composition of an individual’s care package. Because of this, there is a variation in how much councils allocate in personal budgets for domiciliary care related needs.

SECTION 2: THE PRACTICAL AND POLICY IMPLICATIONS OF THE GOVERNMENT’S COMMITMENT TO PROMOTE PERSONALISATION OF SOCIAL CARE, INCLUDING PERSONAL BUDGETS AND DIRECT PAYMENTS

15. Personalisation remains at the heart of social care transformation. The use of self-directed support can offer increased choice and control for people, as well as having a positive impact on people’s health and wellbeing. However, councils should be realistic about the costs and benefits of introducing personal budgets and their implications for planning. The practical implications of personalisation include the following.

Personal Budgets are unlikely to result in Significant Cost Savings for Councils

16. Audit Commission research found that 36% of councils cited personalisation as a driver of better value for money in 2009–10. This rose to 45% in council plans for 2010–11. Better value came mostly from improved outcomes, not savings (Ref 2). This suggests personal budgets offer improved outcomes for a similar, or slightly reduced, spend.

17. Savings, if any, came from:
   — close analysis of financial data, leading, for example, to decommissioning of some poorly commissioned high-cost care packages;
   — people making better use of resources when in receipt of a personal budget and therefore requiring less money to meet their needs;
   — improvements in the delivery of personal budgets, including better audit procedures to increase recovery of unused funds; and
   — rationalising the range of packages.

There is a Tension between Personalisation and Block Procurement

18. Personalisation has fundamentally changed the way that councils procure adult social care services. There is a tension between personalised, local services, and increasing buyer power through block procurement. Our research found that only 15% of councils were using collaborative procurement. This is most commonly through procurement clubs with other local authorities or through joint commissioning with the PCT (Ref 2).

19. Councils should identify the block contracts most at risk from personal budgetholders making different choices. In-house service provision is at risk for the same reason and needs reviewing. Councils are reducing in-house provision and transferring care to independent providers.

20. Figure 6 shows there is a large variation in the proportion of day care services provided in-house by councils and in the total cost of these services. Those councils with high-cost services and a high proportion provided in-house will face financial and operational challenges if personal budgetholders choose alternatives. Our research showed this was a service where individuals with personal budgets looked for such alternatives.
Figure 6

PROPORTION OF DAY SERVICES FOR OVER 65S PROVIDED IN-HOUSE AND THE PROPORTION OF THE BUDGET SPENT ON IN-HOUSE SERVICES

<table>
<thead>
<tr>
<th>Proportion of over 65s’ day services</th>
<th>Proportion of older people’s budget spent on in-house day services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Councils</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>2%</td>
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<td></td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>6%</td>
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<td>8%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>14%</td>
</tr>
</tbody>
</table>

Source: Audit Commission analysis of NHS Information Centre PSSEX1 data for 2008/09

Councils should reconsider their Roles and Relationships

21. The introduction of personal budgets means that:
   — Councils will have to work with care providers and other stakeholders to influence services and ensure they meet personal budgetholders’ needs.
   — Councils will have a greater role in providing information and support to personal budgetholders, other service users, and those paying for services out of their own pocket (self-funders). Councils can deliver information and support directly or by commissioning others to do so.
   — Councils should monitor provision of care to ensure high standards and ongoing levels of satisfaction from personal budget holders. A recent NAO report emphasises this view (Ref 5).

Personal Budgets increase the risk of Misuse of Funds

22. Personal budgets represent a change to the delegation of financial control and service delivery. They potentially contribute to improved quality of services, but they also increase the risk of fraud, corruption or other misuse of funds.

23. Misuse of funds may be by either personal budgetholders abusing the budget, or by their carers taking advantage of the personal budgetholder’s access to the funds. Participants in Audit Commission research did not report significant causes for concern, but the national data cannot corroborate this as it does not routinely report on personal budget fraud (Ref 6).

24. Experience from direct payments so far suggests that levels of abuse are low. The Audit Commission fraud reporting process has, however, received information about direct payment fraud.

25. Social workers can play a key role in the personal budget process by ensuring the scope for financial abuse is kept to a minimum at the care plan assessment stage and in the monitoring and safeguarding process thereafter. We believe the risk of fraud is reduced when social workers receive appropriate fraud awareness training (Ref 7). This should include being made aware of the signs and consequences of fraud and of the need to work closely with audit and counter-fraud specialists should suspicions arise. Councils should also seek to strengthen and promote whistleblowing arrangements among staff, care providers and the public to encourage early identification and reporting of fraud or financial abuse.

Councils should review their Financial and Information Systems

26. Councils taking part in Audit Commission research stressed that effective IT for care management and finance underpinned successful transition to personal budgets (Ref 6). Participants suggested that IT must
support budget monitoring, recording of personal budgetholders’ spending and outcome recording. Systems should also enable personal budgetholders to view information electronically.

27. Reviews of financial and information systems should ensure councils can deliver personal budgets and do not create bureaucratic obstacles:
   — Medium-term financial plans must show the likely demand and costs of personal budgets and the implications for future budgets.
   — Management accounts, financial reporting, management information and councils’ approach to financial control and monitoring all need to change to adapt to personal budgets.
   — Reviews of management information systems should ensure they deliver relevant information for decision making and performance review.

Personal Budgets are Increasing in Prevalence

28. The total number of personal budgets delivered by councils across England doubled to 338,000 in the year to March 2011. In March 2010 168,000 were being delivered and in March 2009, 93,000. However, progress remains variable across the country (Ref 8).

The data from councils responding to Audit Commission research in 2010 shows between 13% and 59% of older people have a personal budget at each council, or an average of 34%. On average, 50% of adults with physical disabilities have a personal budget (Ref 6).

SECTION 3 THE PRACTICAL AND POLICY IMPLICATIONS OF THE GOVERNMENT STATED COMMITMENT TO PROMOTE INTEGRATION BETWEEN HEALTH AND SOCIAL CARE SERVICES.

Variation in the Extent of Integration

29. Integrated working across health and social care offers potential both for efficiency savings and improving outcomes for people. However, the extent of joint working varies across the country. Analysis of adult social services efficiency savings in 2009–10 and 2010–11 showed that integration and working more closely with the NHS was one of the least common ways of achieving efficiencies. Figure 7 shows that more councils plan to focus on this area of partnership working in future.

**Figure 7**

COUNCIL EFFICIENCIES IN 2009–10 AND PLANNED EFFICIENCIES FOR 2010–11 (REF 2)

<table>
<thead>
<tr>
<th>Category</th>
<th>2009/10</th>
<th>2010/11</th>
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</thead>
<tbody>
<tr>
<td>Procurement</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Prevention</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>Back office</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Staffing</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>Changing the balance of care</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Personalisation</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Partnership</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Assessment and care management</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Charging</td>
<td>0%</td>
<td>20%</td>
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</table>

Source: Efficiencies statements (2009/10 and plans for 2010/11) from the Care Quality Commission Self Assessment Survey 2009/10, adapted by the Audit Commission 2011

Practical Implications of Integration

30. Participants in our 2009 research identified many intangible, qualitative outcomes from joint working, although these typically benefited the partner organisations rather than individuals. The outcomes included
sharing skills such as contracting for services, gaining trust and sharing responsibility for achieving outcomes (Ref 9).

31. Our research has identified a series of issues that need to be overcome to ensure successful integration:

— **Silo working.** As financial constraints increase, there is a danger that both the NHS and councils will focus solely within their own organisations when seeking to make efficiency savings. But cuts to one part of the care system can lead to unintended consequences elsewhere, such as new pressures or rising demand. It is therefore important for partnerships to take a rounded, whole-system view of value for money. Health and wellbeing boards will have an important strategic role to play in providing leadership and in building the local picture.

— **Governance.** Arrangements can be complex, requiring careful consideration of accountability and governance frameworks. Not all bodies understand the available options or are always able to specify the powers used to enable their joint financing approach. There are several models of integration—from wholly integrated care trusts that jointly provide and sometimes commission services, to aligned services, where partners agree to work on shared priorities while keeping management of budgets, monitoring and reporting separate.

— **Data.** Integrated services require joint approaches to data collection, information-sharing, record-keeping and management information to inform commissioning and expenditure decisions. However, alignment and synchronisation of data systems is not always easy in practice. Partnership agreements often fail to include quantifiable outcome measures, and partners rarely monitor them when they do.

— **Leadership.** Local history, leadership and relationships can build a shared sense of direction and cement joint working. Clear leadership is vital to engage staff with the new integrated ways of working, particularly where there are joint appointments. Conversely, a lack of focus by senior management can lead to the dissolution of joint financing arrangements.

32. The Audit Commission developed the *Using Joint Financing to Improve Outcomes toolkit* in 2010. It is designed to help auditors identify how councils and PCTs can use joint financing arrangements to improve outcomes, transform services and deliver value for money.

33. We are currently working on a briefing on value for money in the health and social care interface and we will send the Committee a copy when it is published (Ref 10).

**References**


Ref 10 Audit Commission, *Value for money across the health and social care interface*, to be published.

**October 2011**

**Written evidence from the Association of British Insurers (SC 28)**

1. **The ABI**

— The ABI is the voice of insurance, representing the general insurance, protection, investment and long-term savings industry. It was formed in 1985 to represent the whole of the industry and today has over 300 members, accounting for some 90% of premiums in the UK.
— The insurance industry is uniquely placed to assist with a programme of social care reforms and relieve some of the burden off the State. The ABI wants to work with policymakers to help create sustainable funding solutions for the future which lead to a more resilient and better financially protected society. The ABI has been developing policy and actively engaging with key stakeholders to promote the importance of building a more resilient society, particularly through work on long term care provision, protection products, and through our savings and pensions work.

2. Summary

— The ABI supports reform of the social care system to make it simple and easy for care recipients and their families to interact with.

— The ABI is ready to support the Government, and are currently co-leading one of six work streams as part of the Caring for our future engagement.

— The ABI are seeking cross-party support for reforms, which will help us and the public have confidence that we have a system that will last the distance.

3. The Insurance Industry’s Role

— The financial services sector, which includes insurance, has an important part to play. The sector, through its products and advice services, can help people fund their share of the care partnership.

— Insurers are interested in understanding the level of need that exists for social care and how financial products can help people to meet those needs. The level of need is impacted upon by proposals from the Law Commission, Dilnot Commission and the Government.

— The ABI believes the right products and advice that people should have depends on their stage in life. For example, our presumption is that people at working age will have different resources and demands to people in need of care in the near future. In light of this, we are considering how to ensure the right advice and products “wrap around” the individual and their family at each key decision point throughout their lives.

— We have started to identify the key decision points that are needed at each life stage. These occur:
  — during working life,
  — at retirement,
  — during retirement,
  — at the point of needing care, and
  — while receiving care.

— The points that we need to focus on are where people, through a lack of knowledge or encouragement, either fail to make a decision at all, or do make a decision but tend to make the wrong choices through a lack of advice and/or information. An example of the latter is at the point of needing care, where major financial decisions, such as selling the family home or whether or not to self-insure the risk of longevity in care, are often made without taking the appropriate financial advice.

Simple messaging

— The ABI want clarity of messaging about what the State will do and what the individual will be expected to do. This can be taken forward as a nationwide publicity campaign, championed by a trusted messenger.

— The messages must be simple and comprehensible. However, they should not be misleading. Unless the system provides it, people cannot be given the impression that the care costs capped at £35,000 will cover all of their needs once they are in care.

Financial advice and information

— People need financial advice and information at different life stages to help them plan ahead, including for care. We want to work together with other stakeholders such as Government, third sector organisations and our financial services colleagues to help people get the financial advice and information they need to make the right decisions about their resources at each key decision point in their life.

— The ABI notes and supports the Law Commission recommendations of information, assistance and advice.

— The proposed partnership model brings together the public and the private sector funding streams. In order to help the individual, we would like to explore how the public and private sector systems can work together seamlessly. This can include through common terminology. It could also include common eligibility triggers.
Simple system

— We also want clarity in the system. It will also help define the gap between the reality of costs and what the State will contribute. Without this gap understood, people do not know what they are getting. This makes it harder to convince people of the necessity of planning ahead.

— Financial services products are built to fill gaps or provide alternatives to State provision, and therefore a well-defined gap will also allow product innovation and adaptation. As we work with government and other stakeholders on the specifics of the framework we can explore how the industry may be able to develop products that align with and are tailored to the resulting framework.

— In addition to people’s unwillingness to plan ahead and consider their mortality, there are also disincentives in the system. The disincentives in the system are multi-dimensional:
  — the current means test can disincentivise people from planning ahead, because the State safety net provides most, if not all, of the benefits of self-paying
  — the current interaction between the NHS and social care can disincentivise either party from providing the best care for the public, forcing them to focus on finding ways of shifting cost to the other;
  — the care home owners can be disincentivised from taking on publicly-funded residents, because self-funders are required to cross-subsidise publicly-funded residents or third party top-ups are needed
  — local authority budgets and their limitations do not provide enough incentive for local authorities to provide care when it is needed (and as a result, most local authorities have set their care eligibility level at either substantial or critical)

Therefore, we want to work with Government to analyse whether the disincentives benefit the system and whether there could be incentives that promote planning ahead.

4. Conclusion

— We understand that we can only be part of the solution. We want to work with the Government, the public, private and voluntary sectors to create a sustainable care system. We also want to ensure that reforms gain cross-party support, which will give the public and the private sector a level of confidence that does not currently exist in the system.

October 2011

Written evidence from Partnership Assurance (SC 36)

1. Background

(i) Partnership

Partnership is the largest provider of Long Term Care annuities in the UK, with circa 80% of the market by policy and premium.

Partnership is a specialist provider of financial solutions for people with health and lifestyle conditions, as well as those suffering from a serious medical impairment. It has a unique mortality data set and is an expert in pricing longevity risk.

It has been a consistent innovator developing this sector by championing the needs of those with even modestly reduced life expectancies. Partnership was judged “Best Long-term Care Provider” at Health Insurance Awards 2009, 2010 and 2011.

(ii) Introduction

Partnership welcomes the opportunity to respond to the Health Select Committee’s inquiry and would welcome the opportunity to submit oral evidence if called upon.

Partnership’s financial services expertise means that it is best placed to respond to “the practical and policy implications of the Government’s plans for funding social care, and the recommendations made by the Dilnot Commission and the Law Commission”.

This response is focused specifically on the 41% of people who are self funders in the current care system having assets (including property) of more than £23,250 in England. We have campaigned for all self funders to receive appropriately qualified financial advice.

Of the 53,000 self funders who entered residential care in 2009 only 7,000 received appropriately qualified financial advice. The Local Government Information Unit’s Independent Ageing report 2011 estimates 25% of self funders deplete their capital prematurely. Partnership estimates this costs the state £1 billion each year (in England alone).
2. Summary

Partnership welcomes Andrew Dilnot’s report which is a thoughtful contribution to the care debate.

2.1 Law Commission

- This is a much needed rationalisation which provides a clear, modern and effective legal framework.
- Recommendation (6) is important, as it upgrades a local authority’s responsibility to provide information, advice and assistance from a “power” to a “duty”. Currently only 3% of councils provide a list of Independent Financial Advisers to advise on care funding products (LGiU).

2.2 Dilnot’s proposals

- We support the majority of Dilnot’s proposals. The following are particularly important.
  
  * The government should invest in an awareness campaign to encourage people to plan for later life.

- This is fundamental to the growth of a financial services market to fund care.
- There is a chronic lack of awareness amongst the general public of how the care and support system works; what it costs; the likelihood of need; and the fact that many will have to fund it for themselves. This lack of awareness and lack of incentive has lead to a failure of demand.
  
  * Policy Exchange’s report “Careless, Funding Long Term Care for the Elderly” June 2010.

- For this reason we also believe that the following proposal is also extremely important.
  
  * The Government should develop a major new information and advice strategy to help when care needs arise. This strategy should be produced in partnership with charities, local government and the financial services sector.

- Partnership has been working to help provide tailored advice to meet consumer needs. An example of this is www.payingforcare.co.uk an information website which is unique in connecting members of the public with specialist financial advisers.

2.3 Confusion and Dilnot’s principal Care Capping Recommendation

- At the heart of these recommendations is a Cap on Social Care Costs of £35,000.
- This is widely understood by many to mean that all costs will be met by the Government once they have paid the first £35,000 of their social care costs. This is simply not the case for those in residential care and has led to significant confusion.
- For those in residential care the state only meet social care costs and not hotel costs (the costs of board and lodging) and general living costs. This is fundamental as these costs are “typically two or three times as large as personal care and nursing costs taken together”. (OECD report: Help Wanted? Providing and Paying for Long Term Care, June 2011).

- Others may also think their contribution to hotel costs is limited to “general living costs” up to £10,000 a year. However typical fees for the many quality care homes can be nearly £50,000 p.a. This exceeds the standard local authority allowance (the Dilnot report assumed £28,000 p.a.)—requiring individuals to top up the difference from other sources. Few consumers (and senior representatives from local authorities) appear to be aware that they will have to meet these additional costs and are unlikely to plan for them.

- Partnership estimate that if Dilnot’s proposal were implemented in full, one of our typical policyholders (who will on average live for four years) in a quality care home will still have to meet up to 90% of the costs of residential care that they already pay.

- There are many other areas of confusion (eg the local authority will only estimate a notional cost of care as opposed to receipted care and confusion about what is actually covered in “social care”). Without clarity about what is covered it is impossible to plan effectively.

2.4 Climate to create the Growth of Financial Services and Insurance Products

- Pre-funding Long Term Care insurance will not work.
- Immediate Needs Annuities (INAs) can play a significant role in meeting the needs of self funders now. The PSSRU estimates that 45,000 self funders or 40% could potentially take up INAs based on affordability and net benefit criteria. This has the potential to transform the INA market to a £4 billion market. This is equivalent to the UK’s PMI market which supports many providers and operates alongside the NHS which is free at the point of demand.
- Partnership has both the data and the appetite to underwrite the entire immediate needs market, thereby providing genuine tail risk insurance against personal catastrophic loss.
— We do not believe the £35,000 social care cap can help the development of products for the reasons given above (the majority of the costs for self funders in typical quality residential care homes still must be met and there is confusion about what the individual will have to fund themselves in terms of care).

— Pensions and Equity Release will provide an important source of funding for Long Term Care. The Government should focus on driving up pension savings and making pension decumulation options more flexible in regard to Long Term Care costs as history shows getting consumers to save for highly uncertain specific events, such as Care costs, has not worked in the rest of the world.

— Appropriately qualified advice is critical in this area.

3. Response to Health Select Committee Question

3.1 Law Commission recommendations

(a) This is a much needed rationalisation. It provides a clear, modern and effective legal framework for the provision of adult social care services, where previously by its own assessment there had been “an often incoherent patchwork of legislation, which makes interpretation and application of the law complex and time consuming”.

(b) Of particular note is recommendation (6)—“statute should place duties on local authorities to provide information, advice and assistance services in their area and to stimulate and shape the market for services”. This upgrades the local authority’s responsibility from a “power” to a “duty”.

(c) In 2009 of the 53,000 self funders who entered residential care only 7,000 received appropriate financial advice. We believe the Law Commission’s requirement for Local Authorities to take on a greater role in advising and signposting services to adults needing social care and support, can only be beneficial to self funders who need this critical financial services advice.

(d) Lack of access to appropriately qualified advice and in turn failure to purchase an appropriate financial product is a significant reason why self funders deplete their capital prematurely and fall back on the state.

(e) The Local Government Information Unit (LGiU) report (Independent Ageing: Council Support for Care Self-Funders) found that 25% of self funders fell back on state funding.

(f) Feedback to this report from Local authority respondents in England under-estimated the cost of people falling back on state care by as much as 50% compared to independent estimates of £1 billion.

(g) This duty will hopefully redress the current inadequate system where (according to this report) only 3% of councils (who responded to their survey) provided a list of independent financial advisers who could give advice about care funding products.

(h) In LGiU’s survey 61% of respondents (which includes chief executives, leaders, finance directors, adult service directors and cabinet portfolio holders in the 174 authorities in England Wales that are responsible for care) did not know how many self-funders in their authorities fell back on state care.

3.2 Recommendations made by the Dilnot Inquiry

3.2 (a) The government should invest in an awareness campaign to encourage people to plan for later life.

(i) This is fundamental to the growth of a financial services market to fund care which is itself required to ensure the financial burden on the state is controlled.

(ii) A major cause of the dramatic contraction of the UK Long Term Care insurance market, is a complete lack of awareness among the general public of the issues underpinning funding long term care fees. Lack of both awareness and incentive has lead to a failure of demand as consumers elect denial over action and prioritise spending today over provision for a highly uncertain future event.

(iii) “Careless, Funding Long Term Care for the Elderly”—Policy Exchange June 2010.

“Political uncertainty about the future of social care funding over the last 12 years has caused the private care insurance market to fail. Why pay for something that the State will provide for free”.

“This requires a clear statement from the Coalition Government that free personal care for the elderly cannot be provided entirely by the State”.

Clarity about what the consumer is required to pay for and what the individual has to pay for is critical. Without this consumers are unable to plan effectively for their care provision.
(iv) Consumers have a chronic lack of awareness about:

- **What the Government will pay for and what Consumers are required to pay for.** Many are shocked to discover they need to meet their own care costs and it is not free at the point of demand like the NHS.

- **How many will need care.**

- **How Long they will live in care for.** Average life expectancy in residential care is estimated to be two years three months (PSRRU BUPA). Partnership data indicates that the average life expectancy of our customers is three years and 11 months and 12% will live for eight years or more in residential care.

- **How much care costs.** The majority have no realistic idea of how much care costs. Research conducted on Partnership’s behalf by GfK NOP among over 467 people aged over 50 shows 65% believe care home fees are less than £30,000 p.a., a third under £20,000 and 12% less than £10,000. Quality care home fees (particularly in the South of England) can be up to £50,000 and in cases far more.

- **What funding products are available.** In the same survey most people did not know about any of the funding products available (76%).

- **When surveyed 80% of care homes had never heard of INAs and most social workers are equally ignorant of products available to help self-funders.**

- **Where to get advice.** Of the 130,000 people who entered residential care in 2009, 41% or 53,000 were self funders. However only 7% received appropriately qualified financial advice (Oliver Wyman). This is a key reason why self funders deplete their funds prematurely and fall back on the state.

(v) Without this information people cannot prepare adequately to fund their care.

3.2 (b) **There should be a national care needs assessment with standard eligibility criteria and that these assessments should be portable across Local Authority boundaries.** This is clearly helpful.

3.2 (c) **The Government should develop a major new information and advice strategy to help when care needs arise.** This strategy should be produced in partnership with charities, local government and the financial services sector. Partnership has been campaigning for this measure and supports this proposal fully.

(i) Partnership has spent significant time working with local authorities and other public facing organizations to ensure people who need information and advice receive them.

(ii) Focusing resource to these existing sources of consumer information is clearly important.

(iii) It is clear that providing a “one size fits all” booklet or generic website is not sufficient. Consumers will be making care funding decisions, typically at a time of distress, following an accident. They need help and advice tailored to their needs!

(iv) **Local authorities** are a key point of contact for consumers—and require systems which are focused on individual needs. They should identify self funders well in advance of their need for care. Partnership is working with 30 local authorities to generate awareness of these issues to help develop consumer focused processes to signpost self funders to independent financial advice.

(v) **payingforcare.co.uk** Partnership launched this site in response to a serious information gap about where to get advice on care options and where to get qualified financial advice. We pioneered this having discovered 29 million people “googled” the term “paying for care” and 69% turn to the internet for information on care for older people.

(vi) A duty of care should be imposed on care homes to ensure residents or Powers of Attorney receive appropriate financial advice. Only 7% of Care Homes have relationships with financial advisers, which is surprising as they risk revenue shortfalls without guarantees that residents can meet care costs.

3.2 (d) **There should be better integration between social care and the wider care and support system.** This is a practical and self evident recommendation.

3.2 (e) **Cap the Means Test at £100,000.** This will have limited impact on the number of self funders affected as people with assets (including property) exceeding £23,250 typically exceed £100,000.

3.2 (f) **Confusion—Social Care Cap of £35,000 and Hotel Costs:**

(i) Many misunderstand that all care costs will be met by the Government once they have paid social care costs up £35,000. This is simply not the case.

(ii) The Government will only meet social care and not hotel costs (the costs of board and lodging) and general living costs. This is fundamental as these costs are “typically two or three times as large as personal care and nursing costs taken together”. (OECD report: Help Wanted? Providing and Paying for Long Term Care, June 2011).

(iii) Others may also think that their contribution to hotel costs is limited to “general living costs” (up to £10,000 a year). However typical fees for many quality care homes can be nearly £50,000
p.a. which exceeds the standard allowed by local authorities—requiring individuals to top up the difference from other sources. Few appear to be aware that they will have to meet these additional costs and are unlikely to plan for them.

(iv) Partnership estimates that were Dilnot’s proposals implemented in full, one of our typical policyholders (who on average live for four years) in a quality care home will still have to meet 90% of the costs of residential care that they already pay.

3.2 (g) How much social care will cost—potential areas for confusion:

(i) Notional Cost of Care: Consumers may believe that all they need do is provide £35,000 care receipts to a local authority to demonstrate they have met this cap. However local authorities will make an estimate based on the “notional amount” it would have cost them to provide a care service for one of their maintained residents in a basic home. This may be far less and consumers may spend far more than £35,000 as they seek to reach the cap.

(ii) What does “social care” include. It is not clear what costs will be included within “social care”—ranging from help in the garden to preventative activity like a stair support. This is the same for informal care.

(iii) Without clarity it is extremely difficult for people to plan adequately for their care costs.

3.3 Create a climate in which a financial services and insurance industry can grow

3.3 (a) Pre-funded Long Term Care insurance will not work.

(i) Partnership suspended the last pre-funded product in the UK in 2010. This is because of two significant problems—no one wants to buy it and no one wants to provide it!

(ii) From an insurers perspective, over a 20+ year time line where the “care deal” is unknown at the outset, it is impossible to assess insurance risk accurately enough to guarantee terms.

(iii) From a consumer’s perspective an event which may never materialise in the future (a 65 year old man has a 20% chance of going into residential care) is unlikely to entice them to forgo consumption now.

(iv) If consumers are unable to fund pensions which they are likely to require it is unlikely they will save enough for a far less likely event.

3.3 (b) Immediate Needs Annuities (INAs) can play a significant role in meeting the needs of self funders now:

(i) INAs provide an income for life to fund care costs in return for a one off premium. Provided the income is paid to a registered care provider it is tax free. This product is portable and provides peace of mind. Any residue can be left, typically as a bequest, to family.

(ii) Professor Forder, PSSRU estimated the potential take up of INAs by self funders based on affordability and net benefit tests to be 45,000 or 40% of all self funders—rather than the 4% who currently purchase these products. This would transform the INA market to a £4bn market equivalent to the UK’s PMI market which supports many providers and operates alongside the NHS.

(iii) Partnership has both the data and the appetite to underwrite the entire immediate needs market, thereby providing genuine tail risk insurance against personal catastrophic loss.

(iv) Research post- Dilnot by PSSRU demonstrates that the proposed £35,000 cap, will make INAs more affordable and increase potential take up further.

(v) INAs are easy to understand and simple to explain. There are no claims assessment as the policy automatically pays until death and no uncertainty over future social and political landscape. Also there is reasonable Tax treatment

(vi) Insurers have adequate information to assess likely insurance risk. INAs at point of need are a classic insurance proposition enabling the insurance industry to pool these risks and allow consumers to swap uncertainty for certainty.

3.3 (c) The likely financial services product which will grow:

(i) Lack of clarity about the social care offer together with the need for most self funders in quality residential care homes to meet most of their costs, suggests that the proposed £35,000 cap will not generate a significant financial services market in its own right.

(ii) Pensions and Equity Release are likely to provide necessary sources of funding to meet care costs.

(iii) Critical within this is the advice process. Sufficient adequately qualified advisers who are able to advise individuals on the management of resources in the approach to retirement, at retirement and during retirement to meet the consumer’s changing needs, will be fundamental.

(iv) The Retail Distribution Review (RDR) will require more advisers to achieve the CF8 qualification, enabling more advisers to advise on care products. Currently only 8,000 advisers have this qualification.
(v) SOLLA (the Society of Later Life Advisers) is an independently audited society of advisers skilled in providing advice to the elderly which provides a valuable consumer benchmark for advice.

October 2011

Written evidence from Professor Ann Mcdonald (SC 37)

Short summary of evidence submitted by Professor Ann McDonald, Professor of Social Work, University of East Anglia:

Para. 1: Support for the Law Commission’s recommendations of an Adult Social Care statute, but with an emphasis on rights.
Para. 2: Personalisation—a plea for more research before the widescale adoption of personal budgets for all user groups in social care.
Para. 3: Paying for care—advocates placing NHS Continuing Care on a clear statutory basis which clearly delineates the boundary with social care.
Para. 4: Integration of Health and Social Care—discusses the benefits of a Single Assessment Process and of Practice Based Commissioning.
Para. 5: Economic Regulation—supports the revival of grant aid for voluntary sector community groups.
Para. 6: Training—examines the training needs of a professional social care workforce, and asks for this issue to be incorporated into systems reform.

1. The Law Commission’s Recommendations

The Law Commission’s recommendations that Adult Social Care law should be simplified are welcome. The current complexity of the law makes it difficult for practitioners to understand the legal framework within which they make decisions, and for service users to challenge the decisions that are taken. The incorporation of guiding principles into decision-making will help to structure professional discretion (as happened with the Mental Health Act 1983 and the Mental Capacity Act 2005) and should lead to greater transparency. It is important that such principles emphasise the social model of disability, the importance of choice and the primacy of Human Rights based arguments in support of dignity, respect for family life and privacy. It is unacceptable that people in need of social care services should be denied assistance with basic bodily functions, or be required to accept institutional care in order to receive services over a twenty four hour period. The issues are well stated in the dissenting judgement of Lady Hale in the case of R(McDonald) v Kensington and Chelsea London Borough Council [2011] UKSC 33. In short, a rights-based approach to social care is necessary in which statutory duties are not diluted by financial pressures or changes in the availability of resources. A rights-based approach would also support the portability of care plans from one local authority area to another.


2. Personalisation

Enthusiasm for the development of personal budgets has developed from rhetoric rather than from a strong research base that assesses outcomes for all user groups. Older people in particular may feel daunted by the expectation that they will manage complex financial arrangements when they are unwell or in crisis. Further research is needed to show whether outcomes are improved, and for whom personal budgets are most likely to be successful. Care should be taken not to replicate the sort of complexity created by the wholesale introduction of Care Management as a system in the 1990s, when many service users did not want and did not benefit from such an approach.

Personalisation, in the sense of a more individualised approach to care planning, is not necessarily dependent on the economic model of personal budgets and can be achieved through the improvement of assessment regimes and the regeneration of social care services.


3. Paying for Care

The Dilnot Committee has looked at a number of different models by which individuals may contribute to the cost of their care. If charging for services for people with complex needs is to remain, it will only be acceptable if a clear line can be drawn between social care and health care. Currently, policies on Continuing Care as a NHS responsibility are narrowly interpreted and applied to deny NHS responsibilities to many people at the end of life. Placing NHS Continuing Care duties on a statutory basis would clarify the responsibilities of different agencies and support consistency in application.
An area in particular need of additional funding is services for carers. The current emphasis on the legal duty of assessment leads to expectations that identified needs will be met but current funding is inadequate for this.

4. Integration of Health and Social care

The integration of assessment regimes in health and social care (such as the Single Assessment Process for Older People) would avoid unnecessary duplication of visiting time by professionals for the carrying out of sequential assessments. Enabling assessors to provide or to commission both health and care services avoids both unnecessary delay and the risk of gaps in service provision. The development of Practice-Based Commissioning will enable services to be developed to meet very local needs—particularly important in rural areas.

5. Economic Regulation

The voluntary sector has experienced instability as a result of changes in funding policies. The restoration of grant aid would enable community organisations to invest in infrastructure and to develop their planning more confidently. The uncertainty generated by the introduction of personal budgets has undermined the ability of organisations to provide services for marginalised groups, because of a lack of critical mass. Again, this is likely to have an impact on the range of services available, particularly in rural areas. Some core investment is needed for vulnerable groups who are otherwise isolated within their own communities, for example people with dementia, or those with complex needs and challenging behaviour. Private providers may need to be given incentives to enter such a market, and may need access to the expertise of the statutory sector as a partnership in care delivery, rather than relying on market principles to meet demand.

6. Training

Attention needs to be given to the type and level of training for staff in health and social care to be able to respond to demographic changes and new institutional patterns. The creation of the College of Social Work to take forward the recommendations of the Social Work Reform Board provides an opportunity to support employers and Higher Education Institutions in recruiting and developing an appropriately skilled workforce. Post qualification training (at masters level) is particularly important to produce professionals with the skills needed to intervene in complex situations, like adult protection and mental health, and to provide supervision and leadership for others.


October 2011

Written evidence from Parkinson’s UK (SC 50)

Summary
— The social care system is chronically underfunded. This leaves many people with Parkinson’s experiencing poor quality care or denied access to services.
— Additional funding from government is required to sustain care and support in the future in order to meet the needs of an ageing population.
— The Department of Health should work across government to make an economic case for investment in social care. There is a case for the White Paper on social care to be sponsored across government.
— The Dilnot Commission provides a welcome framework on how to make the system more equitable, particularly for those in residential care. We urge government to implement its recommendations and that of the Law Commission, and legislate swiftly in 2012 for a fairer system of care.
— A major concern for people with Parkinson’s is inequality in accessing and receiving care and support. It is also important the White Paper addresses charging concerns.
— People with Parkinson’s have expressed general dissatisfaction with local authority funding decisions and strong support for entitlements and decisions to be taken at a national level by an independent national body.
— We are disappointed that government has not taken the opportunity to put social care on the same policy and strategic footing as health and public health. There is lack of “carrots and sticks” to make the necessary improvements nationally and locally in terms of delivery and quality in social care.
— For people with long term conditions, such as Parkinson’s, integrated care planning, provision and review is essential. We co-sponsor a project called Neurological Commissioning Support than can provide advice to commissioners on how this can be achieved.
Full Response

1. It is estimated that 120,000 people in the UK have Parkinson’s. Parkinson’s is a progressive, neurological disorder, with no known cure. Parkinson’s affects people from all social and ethnic backgrounds and age groups. The average age of onset of Parkinson’s is between 50–60 years of age, though one in seven will be diagnosed before the age of 50 and one in 20 will be diagnosed before the age of 40.

2. Appropriate social care provision is crucial to quality of life for people affected by Parkinson’s. As the condition progresses and there is a greater impact on daily living activities, this can result in an increased dependency for support and care, either informally or through formal care services.

The Government’s Plans for Funding Social Care

3. Social care funding has failed to keep pace with demography. Since 2004 NHS spend has risen by £25 billion. Age UK has estimated that spending on older people’s social care in that same period rose by just £43 million, 0.1% in real terms. The Department of Health’s own figures show that demand for social care is outstripping expenditure by 9%. 61

4. The chronic underfunding manifests itself in many ways. For example, there is clear evidence of unmet need amongst people with Parkinson’s. A survey of Parkinson’s UK members found, one in five (19%) of people with Parkinson’s who said they needed personal care and support were not receiving any help. Only 11% of carers were receiving support from social services, a fall from 16% in our 1997 survey.

5. The Comprehensive Spending Review announced additional £2 billion in funding for social care each year from 2011–15. However this is against a picture of 27% cuts to council budgets in the same period. A clear pattern of cuts is emerging:
   — A total cut to adult social care budgets of £1 billion in 2011–12. 64
   — Net expenditure on older people’s social care to fall by 8.4% next year. 65
   — A Care & Support Alliance survey showed that services to 24% of disabled adults had already been cut in early 2011, even though their needs were the same or had increased. 66
   — The scaling back of eligibility for services and a number of court challenges. 67

6. The evidence is clear that additional funding from government is required to sustain care and support in the future in order to meet the needs of an ageing population.

7. This debate is separate to the debate over the funding needed to implement the Dilnot Commission’s proposals. Indeed this was recognised by the Commission: “In addition to funding for the new capped cost offer, there will also need to be additional public funding for the means-tested system.”

8. Dilnot did not put a figure on the level of funding needed for the current system, but was “concerned that not all the additional money from government to councils has made its way to social care.” Parkinson’s UK strongly supports Dilnot’s call for resources made available locally for adult social care each year to be transparent and subject to national oversight.

9. When we surveyed people with Parkinson’s for the “Big Care Debate” in 2009 we found that there was general dissatisfaction with local authority funding decisions. Just 12% of people with Parkinson’s believed that decisions about how much money should be spent on care should be made by local government, with 65% favouring an independent national body.

10. Total social care spend is a product of 152 council decisions. We support the King’s Fund analysis that this has been detrimental for social care and that government should adopt a single strategic assessment of the funding needs of the NHS and social care. 68

11. Social care is often seen as a burden on the state, when it should be seen as an investment. It could generate significant savings, for example, by ensuring that people with long term conditions and carers do not have to give up work, and by reducing the need for more costly health interventions. 69

64 ADASS Budget Survey 2011 (2011)
67 For example, Care Quality Commission. The State of Health Care and Adult Social Care in England. (2010) Figure 8, page 35. www.cqc.org.uk/stateofcare.cfm
12. The Department of Health should do more to ensure cross government support from the Treasury and Department for Business, Innovation and Skills on the benefits that could arise from investment. There is a case for the White Paper on social care to be sponsored across government.

Recommendations of Dilnot and Law Commissions

13. Parkinson’s UK strongly supports the contributions from the Dilnot Commission and the Law Commission. Implementation could lead to a more consistent, fairly funded care system that is easy to understand and ensures people with Parkinson’s do not bear the financial burden of their condition. While people affected by Parkinson’s have always supported a free at the point of delivery national social care system, we recognise that this is politically unpalatable in the current funding environment.

14. We particularly welcome Dilnot’s rejection of a voluntary insurance funding model which could lead to discrimination for those with pre-existing conditions such as Parkinson’s, who frequently report difficulties obtaining insurance.

15. In particular, Parkinson’s UK supports the following recommendations:
   — A capping of lifetime costs for care and a more generous means test in residential care.
   — Recognition that younger people cannot afford to contribute as much for their care, through a tiered approach to capping.
   — A new strategy for awareness, advice and information around care and support.
   — The introduction of a national system of eligibility and assessment.

16. However, a Dilnot system will need safeguards. This includes how a notional metering system would work (ie the period when the person’s own expenditure on care counts towards the cap). Councils will be tempted to undervalue this package so it takes longer to reach the point at which they will step in and fund the care.

17. The metering phase need to be “carer sighted”, ie the more care the unpaid carer provides, the slower the progress towards the cap. If assessed needs are fulfilled by family members then the “meter” should start running on the £35,000 cap, otherwise this would be a disincentive for families to care.

18. We believe improvements could be made in respect of Dilnot’s homecare proposals. Currently, those with some income can be left with as little as £160.08 per week to live on while savings from £14,250 onwards are taken into account. We would like to see a raised means-test threshold for homecare, while property assets must continue to be disregarded. This would remove perverse incentives for people to move into paid for residential care early, not build up any savings or to decline costly homecare packages.

19. Parkinson’s UK does not support Dilnot’s suggestion of setting criteria at substantial needs nationally as an interim move. It runs counter to the preventative agenda and it means the metering system will only start when people require substantial care, meaning a person’s own expenditure prior to this will not count. This will be particularly unfair for people with a gradually progressive condition, like Parkinson’s.

20. We welcome Dilnot’s rejection of incorporating disability benefits into the social care funding system. However the Dilnot system will mean self funders in residential care who become “state funded” once the cap is reached will lose their Attendance Allowance (or DLA) at this point. These savings must go back into social care, and not (as happened in Scotland upon the introduction of free personal and nursing care) back into the DWP budget.

21. In principle we object a system that will not cover accommodation costs in residential care. But if implemented then such costs should be capped to a maximum of £7,000 so that costs are affordable. In Scotland accommodation costs were not capped when the free personal and nursing care policy was introduced, so individuals can end up paying over £400 a week in hotel costs.

22. We reject Dilnot’s suggestion that NHS Continuing Care funded residents should pay their accommodation costs. This erodes the principle that NHS care should be free at the point of delivery.

The Scale and Implications of Existing Variation in Access to and Charges for Social Care in England

23. The postcode lottery of care is a major concern for people with Parkinson’s from our surveys and the All Party Parliamentary Group for Parkinson’s Disease Inquiry Report. We are running a national campaign—Fair Care—to address the inequalities that people with Parkinson’s face.

24. A national framework or national standards would create a fairer system and benefit disabled and older people and carers as they would have more certainty about their entitlement and it would reduce the inequity across the country.

71 See our campaigns pages www.parkinsons.org.uk/faircare.
25. Reforms must encompass concerns about charging. Parkinson’s UK is a member of the Coalition on Charging which is seeking a fairer charging system. A recent sample of 15 councils\(^22\) revealed massive increases in costs for hourly and weekly homecare charges. There is evidence that charges lead to people avoiding engagement with social care until crisis point.

26. There should be flexibility for councils not to charge for services, and capping of maximum charges councils are able to make while ensuring there is a more generous disregard so that people are not left in poverty after deductions are made. We note that Wales has implemented a package including maximum £50 a week for community care charges to address these concerns.\(^53\)

27. People with Parkinson’s also want a national body who can hold local authorities to account in order to ensure that people in need are not being denied care. But localism has removed any national oversight of commissioner (council) performance. Instead councils self-report on their performance against a new adult social care outcomes framework.

28. We are concerned that there are no levers or incentives to drive up quality of commissioning and fear that this will lead to more inequity of services. It is not enough for the Department of Health to plead tough regulation of providers and hope for the best on commissioners. It is unclear how effective national HealthWatch will be while NICE Quality Standards will only be good practice.

29. We are calling for social care to gain some strategic equivalence with health and public health. For example through:

- Duties on commissioners to secure continuous improvement in social care;
- A national body (like NHS Commissioning Board and Public Health England) with oversight of performance in the sector;
- Quality Standards and outcomes frameworks that act as levers and attract premiums and rewards on progress towards specific outcomes; and
- a focus on inequalities and national datasets to allow comparison between areas

30. We are also concerned that the funding and delivery proposals for local HealthWatch could leave it a weak vehicle for local scrutiny and calling councils to account. The Future Forum recommended a duty on councils to have regard to HealthWatch investigations\(^74\) but it appears this will not be implemented. There is little detail on the Department’s promise to look at a citizen’s right to challenge poor quality services and lack of choice.\(^75\)

The Practical and Policy Implications of Personalisation

31. We welcome the government’s vision to extend availability of personal budgets, alongside the Law Commission’s proposals for a duty on councils to stimulate the market for social care, and legislate for direct payments to cover residential care.

32. However the rhetoric of personalisation is yet to match the reality on the ground. In 2010 we ran a project to look at people’s experiences of personalisation.\(^76\) People with Parkinson’s reported a lack of good quality information, uncertainty about eligibility, variation in the support needed to help make choices (such as advocacy), assessments that led to very little help and a lack of services to choose from.

33. There was also wariness with the bureaucracy involved in managing payments. Not all people with Parkinson’s or carers wish to use eg. direct payments, and it is important that people are given genuine choice, including the ability to use traditional services.

34. Since that study pressure on social care budgets has led to personalisation being used as a way to reduce costs of care.\(^77\) This is not helped by a system for allocating resources which is opaque and variable depending on where you live.

35. There remain concerns about the conduct and skills of directly employed care workers and we believe there is a need for greater oversight of this workforce. There is evidence that options for background checks are not being used by some people in receipt of direct payments.\(^78\)

36. Finally there needs to be good information on the “marketplace” so the “consumer” can exercise more choice. We are concerned that the information provided by the regulator, the Care Quality Commission, can be out of date by many months or years and registration with CQC is nothing more now than a license to practice.

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\(^22\) Homecare service charges. (2011) http://www.disabilityalliance.org/cochomecare.htm
\(^54\) Parkinsons UK. Choice, control and personalised services—final report (2010)
\(^74\) Radio 4 You and Yours, Charities in social care personal budgets warning (3 December 2010) www.bbc.co.uk/news/uk/11909505
\(^75\) Skills for Care. The Employment Aspects and Workforce Implications of direct payments (2008)
Economic Regulation of the Social Care System

37. The developments at Southern Cross also bolster our case for government oversight of commissioning behaviour in both residential and domiciliary care markets. Many councils are retendering domiciliary care contracts with the aim of cutting numbers of providers and costs. The pattern emerging is of bigger national companies undercutting smaller local providers. We therefore support economic regulation provided that the focus of competition is on quality.

Integration between Health and Social Care Services

38. While Dilnot does not propose the end of a means tested social care system, a reduction in the catastrophic costs of social care could help reduce the unfairness experienced by people deemed in need of social care rather than health care.

39. However the gap between health and social care will remain and it is essential that councils and the NHS use every opportunity to build a care service based around the person. This is particularly important for someone with a long term condition such as Parkinson’s where integrated care planning and review is essential.

40. Good commissioning of integrated services for people with Parkinson’s can save up to £56 million, for example with investment in community and rehabilitative services. We co-sponsor the Neurological Commissioning Support project with the MS Society and Motor Neurone Disease Association. This provides guidance to commissioners on how to commission for quality neurological services including across social care. We have also been involved in research on care pathways, including social care, for people with neurological conditions, which found rehabilitation and day opportunities are important priorities.

41. The last decade have seen integrated service projects that prove there can be cost savings and better outcomes for people. However progress is still piecemeal rather than widespread.

42. We welcome the focus of integration in the new health reforms. However, the lack of levers and scale of cuts in social care mean there remain questions on how to really make integration happen. In an increasingly crowded health landscape we are concerned that social care will remain a poor relation.

October 2011

Written evidence from Nuffield Council on Bioethics (SC 58)

1 Following a two-year inquiry, the Nuffield Council on Bioethics published the report Dementia: ethical issues in October 2009. The Working Party that produced the report was chaired by Professor Tony Hope of Oxford University, and included members with expertise in medicine, nursing, neuroscience, law, sociology and philosophy, and members representing people with dementia and carers. To inform its deliberations, the Working Party held a public consultation and spoke to people with direct experience of living with dementia and those working in the field. This response highlights the report’s recommendations which are relevant to the Select Committee’s inquiry on social care.

Accessing Services

2. We welcome the wide-ranging debate that is currently taking place around personal budgets, which aim to give people more choice and flexibility over their care. However, after a diagnosis of dementia, people will still need help in accessing what is inevitably a fragmented support system, given the wide range of health and social services which people with dementia and their families may potentially use. Such support may take many forms, but we suggest that a key element will be the identification of a single individual to liaise with the person with dementia and their family, and with whom a trusting relationship can develop. We welcome the proposal in the English dementia strategy to pilot possible models of “dementia care advisers”, whose role would be to help people diagnosed with dementia access appropriate services and support. We suggest that there is a strong ethical justification for such a role to be introduced throughout the UK as soon as possible (paragraph 3.27).

3. People with dementia experience a number of disadvantages in the current system, especially in the way services are subdivided into “social” and “health” services, and indeed they may sometimes get “lost” between the two systems. Their needs are largely classed as “social”, despite the fact that the direct cause of their highly complex symptoms is progressive damage to the brain, and all the evidence suggests that much more skilled care than is currently generally on offer would significantly enhance the quality of people’s lives and promote independent living. Under the current system, this means that support services may only be made available

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80 Please see http://www.csupport.org.uk/ for more details
82 For example, Total Place pilot www.dorsetforyou.com/media.jsp?mediaid=143386&filetype=pdf
when a crisis has already been reached because of the pressure on social services departments to prioritise those in greatest need. Moreover, the level of “hidden” dementia, particularly among those living in care homes, means that even where people are in touch with social care systems, their particular needs arising out of their dementia may not be recognised. The access of people with dementia to the services they need should not be determined by classifications of care. In allocating resources, and in determining standards of care, it should make no difference whether the intervention is classified as “health” or “social”. If the intervention addresses a problem that arises as a result of the disorder then the level of priority given to providing that intervention should be based on the needs of the person and the benefits and the costs of the intervention and not on which service provides it. Any future proposals relating to adult social care services must take this point fully into account, despite the current difficult economic climate (paragraph 4.39–4.41).

Respecting Individual Needs

4. We stress the importance, if care is to be of appropriately high ethical standards, of support that promotes the autonomy and well-being of the person with dementia and that recognises their individuality and value as a person. The National Institute for Health and Clinical Excellence has made a number of recommendations in these areas, emphasising the importance of promoting independence and helping maintain a person’s skills, responding flexibly to fluctuating abilities, providing care in a stable and familiar environment, and enabling the person to participate in activities which they enjoy. The English dementia strategy similarly stresses the importance of community personal support services “ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of broader family circumstances.” The strategy further highlights the role of housing and housing support services in supporting people with dementia to live in their own homes for as long as possible, and the importance of ensuring people are able to “live well” with dementia in care homes. We very much welcome the increasing emphasis on services which are flexible and appropriate to the individual and which enable them to live well with dementia—an approach based on respect for the needs, preferences and personhood of the individual person with dementia (paragraphs 3.30–3.31).

The “Small” Things

5. The responses we received from our various consultative activities suggest that the “small” things—the “micro” aspects of life and their effects—are of considerable significance both to autonomy and well-being. Quality of care and ethical issues are at least as much to do with the everyday as they are with the “big” questions around the end of life. How things are done, so that people with dementia feel valued individuals, will often be far more important than the particular structure or format of services. These “micro” aspects of care are often primarily a question of attitude, of professionals and care workers genuinely believing that the person with dementia for whom they are providing care matters as an individual, and is a “person” in the fullest sense of the word. Such attitudes emerge in such mundane, everyday circumstances as whether a care worker in a residential setting checks whether the person with dementia would like sugar in their tea, or encourages them to express preferences in the clothes they put on in the morning (paragraph 3.5).

Care Partnerships

6. Carers will often know the person with dementia better than anyone else, and hence are likely to be well placed to advise on their particular support needs. However, they do not necessarily know about the nature or progression of dementia, nor what care interventions are possible. Support is therefore needed from professionals who do possess such knowledge. Conversely, health and social care professionals will be familiar with care planning, care provision and care giving, but unfamiliar, at least initially, with the personal history, preferences and values of the person with dementia. It is therefore crucial that professionals and carers work together in genuine partnership, in order to ensure that people with dementia benefit from their joint expertise and joint knowledge. Such a “care partnership” should be founded on a basis of mutual respect for the different forms of knowledge of the different parties, and on the premise that all concerned are seeking to help the person live as well with their dementia as possible. It is important to ensure that where formal services are available, they should be offered on a flexible basis, matched to the actual needs and wishes of those receiving them and to the support that carers are able and willing to offer (paragraph 7.20–7.21).

Financial and Social Support for Carers

7. Caring for a person with dementia is expensive. Costs incurred by carers include factors such as lost earnings, paying for respite and other care, and investing in adaptations and assistive technologies for the individual for whom they are caring. The financial impact on the household may be even more dramatic in cases of early-onset dementia where the person with dementia is the primary breadwinner in the household at the time of diagnosis. A carer’s needs for support are not limited to financial matters, but also encompass emotional and practical support. Some carers find it very difficult to ask for the help that they need in order to cope with the situation in which they find themselves, especially where their adult identity has been based on a solid foundation of competence, capability and independence. Our emphasis on solidarity highlights society’s responsibility to support people with dementia and their carers. This responsibility extends to informing carers, openly and systematically, of the social and financial support to which they are entitled: support should not only be available to those who know enough about the system and have sufficient persistence to assert their
rights. We again commend the proposed role of a dementia care adviser or similar (see above) who should be well placed to ensure that carers of people with dementia are better informed about their entitlements. A timely diagnosis is also important for carers, given that without such a diagnosis carers will experience significant difficulty in obtaining the help and support they themselves need (paragraph 7.27–7.30).

8. It is also essential that carers are supported in considering their own interests, as well as those for whom they care. However, it may be very difficult for a carer genuinely to consider their own interests alongside those of the person for whom they care, even if they know that this is what the person with dementia would have wished. Professionals such as doctors, nurses, clinical psychologists and social workers have an important role to play in supporting carers explicitly to consider their own needs and interests when weighing up difficult decisions, particularly around future care options (paragraphs 7.35–7.37).

Dementia: An Ethical Framework

9. These recommendations are based upon a six—part “ethical framework” set out in the Council’s report. As with any framework, it will need to be applied flexibly, and with compassion. There will rarely be one “right” answer to any particular ethical difficulty.

Component 1: A “case-based” approach to ethical decisions: Ethical decisions can be approached in a three-stage process: identifying the relevant facts; interpreting and applying appropriate ethical values to those facts; and comparing the situation with other similar situations to find ethically relevant similarities or differences.

Component 2: A belief about the nature of dementia: Dementia arises as a result of a brain disorder, and is harmful to the individual.

Component 3: A belief about quality of life with dementia: With good care and support, people with dementia can expect to have a good quality of life throughout the course of their illness.

Component 4: The importance of promoting the interests both of the person with dementia and of those who care for them: People with dementia have interests, both in their autonomy and their well-being. Promoting autonomy involves enabling and fostering relationships that are important to the person, and supporting them in maintaining their sense of self and expressing their values. Autonomy is not simply to be equated with the ability to make rational decisions. A person’s well-being includes both their moment-to-moment experiences of contentment or pleasure, and more objective factors such as their level of cognitive functioning. The separate interests of carers must be recognised and promoted.

Component 5: The requirement to act in accordance with solidarity: The need to recognise the citizenship of people with dementia, and to acknowledge our mutual interdependence and responsibility to support people with dementia, both within families and in society as a whole.

Component 6: Recognising personhood, identity and value: The person with dementia remains the same, equally valued, person throughout the course of their illness, regardless of the extent of the changes in their cognitive and other functions (para 2.4 and box 2.1).

October 2011

Written evidence from The Princess Royal Trust for Carers and Crossroads Care (SC 60)

Summary

— The recommendations of the Dilnot Commission should be implemented swiftly by the Government.

— The recommendations of the Law Commission should be implemented swiftly by the Government.

— Only a very small minority of carers receive support causing ill health among carers; harming recovery of the person they are caring for; and increasing unwanted admissions to hospital and residential care.

— Councils are still struggling with the implementation of personalisation.

— Carers in some circumstances should be able to purchase replacement care with their own personal budget.

1. The Dilnot Commission

1.1 The Princess Royal Trust for Carers (The Trust) and Crossroads Care support the recommendations made by the Dilnot Commission and believe the Government should act swiftly to implement them. As the Commission reports, demographic changes will increase the population level of need for care and support in future. Without changes to the social care system which is supporting fewer and fewer people, the burden on carers will increase greatly when we are currently at the point for carers, when for many the burden is already causing physical and mental ill health as demonstrated by the statistics below.
1.2 A four year study of 392 carers and 427 non-carers aged 66–92, which found that carers who were reporting feelings of strain had a 63% higher likelihood of death in that period than non-carers or carers not reporting strain.84 Carers providing high levels of care being associated with a 23% higher risk of stroke.85

1.3 52% of carers providing substantial care in one study needed treatment for stress-related disorders.86 In another, over half the sample said they were in good health, but General Health Questionnaires (GHQs) indicated that 94% could be identified as having psychiatric disorders.87

1.4 63% of those with a caring responsibility said they had health problems compared to 48% of those that do not have caring responsibilities.88 Carers providing more than 50 hours of care per week are twice as likely to report ill-health as those not providing care.89

1.5 Increasing the number of people who receive support through the social care system must be a priority for reform to reduce the burden on carers. The Commission’s proposal for a national level of eligibility criteria could enable this especially if that level is set below what councils are currently operating. This would be the case with the Commission’s recommendation that councils should be supporting people assessed to have substantial care needs as those councils only supporting those assessed as critical would have to widen their support. This could be a first step, but greater progress would be needed.

1.6 The more generous means testing regime and cap on total lifetime personal expenditure on care as proposed by the Dilnot Commission would assist carers. In October 2010, we surveyed 800 carers, although this sample was skewed towards carers who prove above average levels of care. 60% of carers surveyed had used all of their savings to cover the costs of caring; 53% had to borrow to cover costs of caring; and 10% of these had borrowed at rates of 41%+ and 62% had borrowed from friends and family.

1.7 We also believe that the creation of a cap on private expenditure could create incentives for councils to invest in preventative measures that limits private expenditure on care below the cap level, meaning reductions in council expenditure on care for those who have gone past the cap level.

2. The Law Commission

2.1 We support the recommendations of the Law Commission, especially the creation of a national eligibility framework for carers as this could increase the number of carers who receive support, and make access to support for carers more equitable throughout England.

2.2 We also support the recommendation that councils have a duty to assess any carer who may have, or will have upon commencing the caring role, needs that could be met by the provision of carers’ services or services to the cared-for person.

2.3 We strongly support the recommendation that community care assessments should not consider if needs are being met by the carer, but record all needs and then record if any needs are being met by a carer who is willing and able. This will increase transparency and knowledge of how much care a carer is providing indicating sustainability, and give local authorities an increased understanding of total need in their area.

3. Increase Support for Carers

3.1 The Household Survey of Carers 2009–10 found that only 4% of carers had been assessed (equal to about 200,000 carers in England) and of those:

- 4% reported getting a break in their own home (9,600);
- 8% reported getting a break away from home (19,200);
- 16% got a direct payment or personal budget (38,400);

42% of carers surveyed had not had a break of more than two days since becoming a carer.

3.2 These poor figures for supporting carers are supported by data collected by local authorities for 2009–10:90

- 415,000 were assessed or reviewed;
- 208,000 received some form of service (eg a break, referred to support group or local carers' organisation or a Direct Payment);
- 179,000 received information only as a result, for example a leaflet.

87 Unpublished 2002 research from Torbay Care Trust and Manchester PSSRU.
3.3 Carers who do not receive an assessment have to rely on the voluntary sector to give them much needed support, however with cuts in funding these free services may become available to fewer people. Furthermore, there is strong evidence that the additional £400 million over four years allocated to the NHS to provide breaks for carers is not being used to for that purpose.91

3.4 Our report, Supporting Carers; the Case for Change,92 shows that increasing support for carers can improve the health and wellbeing of carers, those they are caring for and reduce demand on health and social care services that would save over £1 billion per annum for the NHS and local authorities.

4. Supporting Carers to Improving the Health of Carers and Patients

4.1 A randomised controlled trial (RCT) found that support for the family of stroke patients is linked with reduced depression amongst stroke patients (17%–27%) and a reduced need for physiotherapy.93

4.2 Another RCT assessed the effectiveness of providing three to five sessions of personal care training to carers, each lasting 30–45 minutes. It resulted in a higher proportion of stroke patients achieving independence at an earlier stage, and reduced the need for physiotherapy and occupational therapy. There were also significant reductions in carer burden and improvements in mood and quality of life for carers and care recipients.94

4.3 Evaluations of four re-ablement programmes in England found that carers play a crucial role and involving and supporting them can improve chances of long-term patient re-ablement.95

4.4 17% of carers who had taken a break of more than a few hours suffered mental ill health compared to 36% of carers who did not have such a break since beginning their caring role; 35% of carers without good social support experienced ill health compared to 15% of those with good support.96

5. Support Carers to Reduce Demand on NHS Services

5.1 Hospital admission can be an indication of a breakdown in the caring relationship. A whole systems study tracking a sample of people over 75 years old who had entered the health and social care system, found that 20% of those needing care were admitted to hospital because of the breakdown of a single carer on whom the person was mainly dependent.97

5.2 One study found that problems associated with the carer contributed to readmission in 62% of cases. Carers of people readmitted were more likely than other carers to: be experiencing ill health, fatigue and interrupted sleep; be conducting at least one intimate task; and generally feel frustrated.98

5.3 The previously mentioned RCT in paragraph 4.1 also found reduced hospital days of stroke patients contribute to lower annual treatment costs of £4,043 compared to the control group.99 Another study looking at the impact of support for the family of stroke victims found it produced shorter length of hospital stays than in the control group.100

5.4 Measuring delayed transfers of care is a good indication of how well health and social care services are interfacing. In six months from August 2010 to January 2011, 27,555 patients experienced 660,942 days of delayed transfer of care in England. When annualised, this equates additional costs of approximately £150 million to the NHS. This discounts delayed transfers between NHS funded beds.

95 Pg 31, Homecare Re-ablement Workstream, Care Services Efficiency Delivery Programme, 2007
5.5 In 2010, The Princess Royal Trust for Carers published “Out of Hospital” to help hospitals improve their discharge processes by involving carers.\textsuperscript{101} This guide refers to lessons learnt from pilots in The Great Western Hospital, Swindon and Barnet and Chase Farm Hospital. Key recommendations are:

- include identification, recording and referral of carers in hospital discharge policy;
- collect clinical audit data on the numbers of carers identified and the impact of providing carer support on patients and hospital, eg improved patient experience of discharge, increased hospital efficiency;
- health commissioners should agree carers’ standards as part of the contract with hospital trusts; and
- health commissioners should actively participate in local strategic and developmental work on carers issues, eg local carers’ strategy.

6. Support Carers to Delay the need for Residential Care

6.1 Carer-related reasons for admission to nursing or residential care are common, with carer stress the reason for admission in 38% of cases.\textsuperscript{102} This suggests that giving carers extra support to manage their caring role more effectively and maintain good health could reduce unwanted residential care admissions.

6.2 One RCT of 406 spousal carers of people with Alzheimer’s disease (USA) over 10 years found that those whose carers had received support, including six sessions of individual and family counselling, experienced a 28.3% reduction in rate of nursing home placement and were likely to stay at home for 557 days longer than those whose carers were not supported in this way.\textsuperscript{103}

6.3 A study based in Australia showed that ten sessions of training, which focused on distress and isolation reduction, coping skills, fitness and diet, and social and leisure activities for carers of people with dementia, delayed residential care admission significantly.\textsuperscript{104} An RCT that looked at a Dutch programme of day care-based respite, coupled with carer support and advice, found that the programme achieved significant delays in transfer to residential care.\textsuperscript{105}

6.4 Focusing on meeting the needs and preferences of families, may also help councils to manage their reduced resources. Increasing support for carers can prevent or delay a need for residential care, and reduce the proportion of care in residential settings. Projecting such a scenario entails the consideration of three effects on resources:

- increased expenditure on support for carers;
- increased expenditure on supporting people at home rather than in residential care; and
- reduced expenditure on residential care.

6.5 Our forecasting shows that an extra £119 million spent to support carers and an extra £459 million spent supporting people in their home rather than in residential care, would result in overall savings for residential care for councils in England of over £925 million per annum.\textsuperscript{106}

7. Personal Budgets for Carers

7.1 In some local authority areas, carers are being given personal budgets or Direct Payments but are unable to purchase replacement care with them. This is because replacement care is legally defined as a community care service to the disabled person and replacement care should therefore be part of the community care package received by the disabled person. If the carer needs a break, this should be accounted for within the community care package.

7.2 However, there is no legal reason why carers should not be able to purchase replacement care with their own personal budget if the disabled person who will receive the care consents to it. Therefore, this is a practice local authorities choose to perform.

7.3 The argument for retaining this practice is that a carer’s personal budget should be specifically for them and allow them to do something that they would like to do, possibly when they are having a break, such as

\textsuperscript{106} Conochie, G (2011). “Supporting carers; the Case for Change”. London: The Princess Royal Trust for Carers and Crossroads Care
paying for training, going to the cinema, or purchasing a laptop. Enabling carers to purchase replacement care could lead to community care packages no longer accounting for the need to give carers a break potentially leading to increased pressure on carers.

7.4 However, the counter argument is that many carers care for people who do not get a community care package, increasingly so due to tightening eligibility criteria and therefore have no opportunity to receive a break through community care packages. It seems iniquitous that such carers should then be excluded from purchasing replacement care.

7.5 Secondly, many disabled people are receiving smaller packages of community care support meaning it is less likely that carers are having their needs for a break met through that route. Thirdly, the disabled person may not choose to spend their community care personal budget on replacement care that affords the carer a break; or at the times that the carer would like to take a break.

7.6 Fourthly, breaks are what carers most commonly say they would like and the aim of personalisation is to give personal budget holders choice and control. Yet, this practice prohibits carers from purchasing the very thing they would choose to.

7.7 Local authorities should increase the provision of replacement care within community care packages, thus increasing the breaks carers receive, whilst allowing carers, possibly in certain circumstances such as described above, to purchase replacement care with their own personal budget if the disabled person consents to receiving that replacement care.

8. Satisfaction with Adult and Social Care

8.1 The Select Committee should consider the provisional results from the Personal Social Services Adult Social Care Survey. Those receiving Direct Payments or a personal budget were more likely to report satisfaction with the care and support services received than those receiving home care or day care, which supports Government’s promotion of these.

8.2 However, those receiving day care are more likely to report having adequate levels of control over their daily life and are also more likely to report having adequate levels of social contact. These appear to contradict aims of personalisation.

9. Council Implementation of Personalisation

9.1 We have received information of multiple instances where councils appear to be acting contrary to guidance and law. This commonly occurs when services users find the proposed value of their personal budget or Direct Payment to be substantially different from the traditional care package they were receiving without levels of need changing.

9.2 Two examples are given below:

“People who were attending a day centre funded by the Council are being offered a personal budget equivalent of £10 per week.”

“A couple have been told that instead of 12 weeks a year respite in a nursing home, they would receive a Direct Payment of £700. The council block purchase beds in nursing homes and can’t afford to pay for them as well as giving the equivalent in direct payments.”

October 2011

Written evidence from the British Medical Association (SC 61)

About the BMA

The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine all over the UK. With a membership of over 147,000 worldwide, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

Executive Summary

— The BMA believes that reform of social care services is long overdue.
— The BMA supports greater collaboration between health and social care services and the breaking down of burdensome barriers between health and social care that do not benefit patients.
— The BMA argues that failings in the availability and quality of social care places unnecessary strain on the healthcare sector.

— The BMA favours simplifying and rationalising the legal framework for social care as advocated by the Law Commission.

— The BMA broadly supports the proposals made by the Commission on Funding of Care and Support, led by Andrew Dilnot, and concurs that social care should be funded through a partnership between the individual and the State.

— The BMA is generally supportive of the aim to create a more personalised social care system. However, the BMA has concerns over the expense, complexity and adverse effects of basing a system of social care commissioning upon the choices and decisions of individuals holding personal budgets, rather than for populations and communities as a whole.

The Dilnot Commission and the Law Commission

1. The BMA believes that reform of the chronically under-funded and complicated social care service is long overdue.

2. The BMA applauds the Law Commission’s recognition that the current legal framework is inconsistent and incoherent and welcomes the proposal for a simple and coherent legal framework for adult social care. 108

3. The BMA’s preference for the future funding of the social care system would be through a comprehensive model, based on a partnership of state and individual funding. The BMA supports a system that has fairness and simplicity at its core. The BMA concurs with the Dilnot Commission that at present there is too much uncertainty about what people can expect from the care and support system. 109

4. Through their work as doctors, BMA members have learned that patient-carers are hugely variable in their approaches towards social care. Whilst many carers are selfless and self-sacrificing, others expect the state or their GP to arrange care for their vulnerable relatives. A simpler system, as proposed by the Dilnot Commission, would hopefully combat these discrepancies and ensure that everybody receives fair, affordable and dignified social care regardless of their financial or familial situation.

5. The BMA welcomes the emphasis placed by the Dilnot Commission on the provision of good information and advice concerning social care. 110 Currently a large number of different organisations provide information and advice, which can lead to confusing and even contradictory advice being given. This, in turn, can result in vulnerable people being unaware that they are eligible for state support or benefits. The BMA believes that there is a significant need for an extensive publicity campaign about social care processes, what people must save to pay for, and what is available from the state.

6. The BMA is, however, concerned that the Dilnot Commission does not offer a recommendation for the best solution to social care funding. The BMA believes that basing the “cap” on an individual’s assets as opposed to a fixed “cap” for all would provide a more progressive model for the funding of social care.

Variation in Access to and Charges for Social Care in England

7. The BMA believes that peoples’ assessments and treatment should be based on clinical and social need rather than where they live. The BMA is concerned that the Dilnot Commission did not adequately address the distorting effect of variations in house prices in different areas of the UK.

8. The cost of providing social care varies greatly across the UK. There is also a shortage of care staff in certain regions and the number of care staff with good English language skills is also geographically variable.

9. The continuing fragmentation of the health service, and the move to clinical commissioning, makes it difficult to foresee how the big disparities between what is available in different parts of the country will be eliminated in the future.

10. Variation in social care provision and charges is also a significant problem for people who are trying to decide whether or not to move during retirement. Many people try to plan for their future care but it is difficult to do when care provision and services are so changeable.

11. The BMA believes that this variation in the availability, quality and cost of social care in turn has an impact on the cost of healthcare. A lack of suitable and available social care can result in potentially avoidable hospital admissions and delays in individuals being discharged back into the community.

The Personalisation of Social Care, including Personal Budgets and Direct Payments

12. The BMA is generally supportive of the aim to create a more personalised social care system that is well-informed and responsive to the needs of its users. Personal budgets and direct payments for social care are one of the main areas of focus for introducing a greater level of personalisation. However, the BMA has concerns over the expense, complexity and adverse effects of basing a system of social care commissioning

108 Adult Social Care. The Law Commission, May 2011, p. 8
109 Fairer Care Funding, The Report of the Commission on Funding of Care and Support, July 2011, p. 11
110 Ibid, p. 42–43
upon the choices and decisions of individuals. The BMA believes that this could lead to the oversight of populations and communities as a whole.

13. One such adverse effect could be that the service becomes increasingly fragmented, lacking a coherent system-wide approach. Coordinating social care, especially for the most vulnerable in society, becomes increasingly difficult in such an environment. It is particularly problematic in a system where a multiplicity of providers from different sectors are involved in delivering services, which is likely to lead to service closures, duplications and competing interests.

14. In addition, such a system may also overlook those people who do not want to hold a personal budget for social care and could lead to the neglect of the traditional system that commissions services on behalf of communities and populations. Respondents to the recent Law Commission consultation raised similar concerns about the way in which personal budgets will be allocated.111 Respondents were unclear as to whether personal budgets would be mandatory, and if not, what the selection criteria for personal budgets would be. It was also reported that consultees were concerned that personal budgets had not been tested sufficiently to be put on a statutory footing.

15. The BMA also has real concerns about the Government’s commitment to extending personal health budgets. The Government has pledged to roll-out personal health budgets, including integrated budgets across health and social care.112 It was announced on 4 October 2011 that patients receiving continuing healthcare support from the NHS will have the right to ask for a personal health budget by April 2014. The BMA is concerned that the Government is making commitments to extending and rolling-out personal health budgets and integrated budgets before the pilot programme has finished and the full evaluation has been completed and analysed.

16. The imbalance perceived by individual patients who are heavily reliant on the health service, but who feel they have little or no control over their care and treatment is a very real issue. However, the BMA believes that personal health budgets are likely to lead to a two-tier NHS, wherein NHS patients receive different levels of care depending on whether they are in receipt of a personal health budget or not. This raises significant equity concerns. It is also clear that personal health budgets will add a new layer of bureaucracy and administrative burden. Providing budget holders with the required level of information, advice and support will be an additional call on the time and resources of NHS and its staff, as will the arrangements that will need to be in place to continually monitor and review patients’ use of budgets. With the imminent abolition of Primary Care Trusts (PCTs) as part of the Government’s programme of NHS reforms, it is not clear where these duties will lie in the new system. We therefore believe that the roll-out of personal health budgets should be deferred until the proposed reorganisation of the NHS is complete.

17. The BMA's response to the 2009 Department of Health consultation on direct payments in healthcare sets out our position on personal health budgets in full, and can be viewed at www.bma.org.uk/healthcare_policy/responses_consultations/directpayconsjan10.jsp

Relocation and the Portability of Assessments

18. Some recipients of social care are faced by insuperable barriers when they want to relocate to a different part of the UK. Anecdotal evidence from BMA members suggests that these barriers are particularly noticeable when people are considering whether an aged relative should move nearer to them. It is difficult, or even impossible, to find out what the local provisions are before one has already moved into an area. Indeed BMA members have stated several examples of families moving closer to an elderly relative because the difficulties they faced in moving the relative closer to them were too great to overcome. These barriers are particularly pronounced when attempting to move across the borders of devolved nations.

19. This problem can be especially pertinent in cases of palliative care. A person nearing the end of their life may choose to move closer to their family in order to receive palliative care in a domiciliary setting. However, if the Local Authority delays making a social care assessment the patient may have to be treated in a hospital or hospice rather than at home with their family as they had wished.

20. The BMA argues that any delay in assessment can lead to an unnecessary burden being placed on the healthcare sector. The BMA welcomes the Dilnot Commission’s proposals for improving the portability of social care assessments.

Integration between Health and Social Care Services

21. The BMA believes that the integration between health and social care services seems to be deteriorating rather than improving. However, many people have both social care and healthcare needs and regularly access services from social care providers and the NHS. Whilst it has been possible to draw clear boundaries between health and social care services in the past, these boundaries are becoming increasingly blurred. Peoples’ needs do not always fall neatly into any one sector. As such, it is important to look at how services can be designed to better meet peoples’ needs and how individuals can play a greater role in the design and delivery of their...
own care. There is general agreement that the closer integration of services and resources could secure long-term gains in efficiency, quality and productivity.\(^{113}\)

22. The BMA would welcome a more strategic approach to the challenges facing health and social care services in terms of life expectancy and current health trends. Due to the increase in long-term conditions and co-morbidity, particularly amongst older people, we believe there are dangers in creating fragmented services that separate their management from others within the system.

23. The BMA supports greater collaboration between health and social care services and the breaking down of burdensome barriers between health and social care that do not benefit patients. In order to create seamless integration between health and social care, new pathways will be required to link services to facilitate movement of patients between different care sectors.

24. Integration has been a goal of successive governments for the past 40 years, with few notable successes. There are many questions still to be answered, not least around the funding of the two sectors. These include whether integration and competition can co-exist and how to encourage and enable local integration via national policy. The BMA is currently undertaking a project on integration, including examining doctors’ experience of and attitudes towards integration between health and social care, which will report in the coming months.

\(^{October\ 2011}\)

Written evidence from Carers UK (SC 64)

1. Summary

1.1 Carers UK strongly supports the report of the Dilnot Commission and urges the Government to adopt the recommendations in the proposed Social Care White paper in spring 2012. In addition to these measures on paying for care, the need for additional resources for social care cannot be avoided, in order to overcome the historical shortfall and growing demand.

1.2 It is also crucial that social care reform should not start by assuming an unsustainable level of unpaid care from families.

1.3 In addition to recognising the knock-on consequences for other budgets, particularly health and benefits, is vital that reform is seen through the economic lens of workforce participation.

1.4 Carers UK supports the continued drive towards personalisation, however this must be accompanied by support for families to manage personal budgets and care market stimulation.

1.5 Carers UK strongly agrees with proposals to deliver portable assessments and a national eligibility framework.

1.6 Integration of health and social care services offer real opportunities for better outcomes for carers, promoting family resilience and cost savings.

2. The Urgent need for Reform

2.1 Carers UK welcomed the urgency with which the Coalition Government set up the Commission on Funding of Care and Support following the election and the speed with which the Commission reported.

2.2 Along with the 50 members of the Care & Support Alliance, we believe the Dilnot Commission’s report, alongside that of the Law Commission, forms a strong foundation for fundamental reform of the social care system. As a sector, we believe this opportunity cannot be missed and that it is crucial for the White Paper next year to give firm proposals to deliver the Dilnot recommendations and a long-term, sustainable funding settlement for social care.

3. The Context of Reform: Unsustainable Pressure on Families

3.1 Both the Dilnot Commission and the Law Commission recognise the contribution made by carers. However we believe that it is essential that any reform of the social care system must not be based on models which assume an unsustainable level of unpaid care and support from families.

3.2 Carers UK recognises that some level of input needs to be factored into every care and support model otherwise it becomes unsustainable: the £119 billion\(^{114}\) worth of care could not be replaced and would be unaffordable and, for many, undesirable. Typically care models use the current ratio of carers to disabled people and current levels of care. However these are based on current levels of input from families which are so significant that they are left in financial hardship, in poor health and socially excluded. For example, carers providing significant amounts of care are twice as likely to suffer from ill-health.\(^{115}\)


\(^{114}\) The estimated value of the contribution made by the UK’s 6.4 million unpaid carers—Valuing Carers (2011). Carers UK and University of Leeds.

\(^{115}\) Facts about Carers (2009). Carers UK, based on Census 2001 data
any model which continues to assume this level of input from carers, will be inherently flawed on the basis of both fairness and affordability, and risks significant costs to the economy, society and family life.

3.3 Age projections around care for older people already show that the UK will reach a “tipping point in care” in 2017, where the numbers of carers available to provide care is outstripped by demand.116 Factoring in the both added impact on families of caring for disabled adults and children, and the cuts to social care after April 2011, it is likely that we will already have reached this tipping point in care.

3.4 As a result, Carers UK believes that any reform of the social care system must also rest on modelling which anticipates the low levels of social care that are likely to be in the system by 2015, rather than 2008–09 for which data currently exists.

3.5 Carers UK’s research has consistently shown the high cost this brings to families’ resilience, health, finances, careers and social inclusion:

- One million carers have given up work or reduced working hours as a result of caring responsibilities117 and those carers are, on average, £11,000 a year worse off as a result of giving up work to care.118
- A 2008 survey of over 1,700 heavy end carers set out the cost to family finances. Over half of respondents were in debt and nearly three quarters were struggling to pay household bills.

3.6 The employment impact of unmet need—insufficient social care services—is not only borne by carers, but also by employers and the Exchequer in lost tax revenue and increased benefit expenditure. Evidence from Birmingham University shows that the risks to employment for carers could be between £750 million and £1 billion in lost earnings based on National Minimum Wage levels119—evidence which also suggested that investment in social care could also generate these levels of employment. Neither can we afford for increasing numbers of working age carers being forced out of work, whilst we face rising pensions, health and care bills; alongside a shift in the working age/retired dependency ratio from 4 to 1 to 3 to 1 by 2029.120

3.7 Employers are increasingly pointing to the workforce impact of deficiencies in social care.121 However flexibility within the workplace cannot compensate for poor quality, unreliable or inaccessible social care. Over 40% of carers who gave up work did so due to a lack of sufficiently reliable or flexible services. A similar number, 41% of those who describe themselves as looking after their home and family (85% of whom are women), said “they would rather be in paid work, but services available do not make a job possible”.122

3.8 The peak age for caring, 45 to 65, also often represents employee’s peak of training, skills and experience which employers are at risk of losing at short-notice if the social care system cannot enable families to juggle work and care. The average cost of recruitment, retraining and lost productivity is around £11,000 per staff member lost.

3.9 Alongside factoring in the current, unsustainable pressure on carers, Carers UK strongly urges the Government to ensure that social care reform is seen through these economic and workforce prisms.


4.1 There are several clear challenges for social care funding—the short-term impact of local government spending reductions; a long term funding for social care; and how to protect families from catastrophic care costs. We believe these must be addressed as a matter of urgency.

Current funding levels

4.2 Carers UK has consistently argued for a sustainable long-term settlement for social care. However successive Governments have failed to fund the system to keep up with demand. Even before the current reductions in local government spending, this underfunding resulted in rising eligibility criteria, soaring charges and a shrinking number of families being supported by the social care system—with the number of people receiving local authority funded care at home falling from 489,000 in 2004 to 299,000 in 2009.123 The result is a loss of independence and quality of life for older and disabled people, and reductions in carer support, often so that services simply represent a safety net for families—only available when they are pushed to breaking point and can no longer cope.

117 1 million give up work to care (2009). Carers UK, DWP and Ipsos MORI
118 Out of Pocket (2007). Carers UK
119 The case for social reform—the wider economic and social benefits (2010). HCMS and IASS, University of Birmingham.
121 In particular the 56 members of employers forum Employers for Carers, set up by Carers UK with members ranging from BT and British Gas to small manufacturing companies.
122 Figures taken from six reports from Carers UK’s Action for Carers and Employment partnership, research by University of Leeds from 2004 to 2008
123 Care in Crisis (2011). Age UK
4.3 Whilst we welcomed the Government’s announcement of an extra £2 billion for social care in the Comprehensive Spending Review it is clear that this has not been either sufficient or sufficiently targeted to prevent cuts to social care budgets and services. Findings from an ADASS (the Association of Directors of Adult Social Services) survey of 98% of English councils, showed overall budget reductions of £1 billion for 2011–12, at a time where increased demand should require £425 million worth of new services. ADASS has stated that services will face cuts of the same level or greater in 2012–13.

4.4 The impact on families is likely to be severe. 81% of carers responding to the Carers Week 2011 survey were worried about cuts to care services and almost half (44%) didn’t know how they would cope if support were cut. Carers UK is concerned that these cuts will push some families to breaking point, forcing greater numbers to give up work to care and leaving others simply unable to continue to care.

Future funding

4.5 The Dilnot Commission’s final report of the Commission states that “the Government must devote greater resources to the adult social care system”.124 As the social care system struggles to meet the challenges of long-term underfunding and accumulated unmet need, the current spending reductions and increasing demand, Carers UK believes that, alongside greater integration and better use of existing resources, this need for additional resources in social care cannot be avoided.

4.6 The report of the Commission also assumes the current level of expenditure on disability benefits. However the Welfare Reform Bill includes measures which will amount to an estimated £9 billion of cuts to disability benefits.125 With the potential for hundreds of thousands of disabled people to lose their benefits and an unknown number of carers to lose Carer’s Allowance as a result, we fear that this will lead to substantial knock-on costs for the social care system as independence is lost and family caring scenarios become financially untenable.

4.7 In a challenging spending environment, we feel that there is a strong economic case for funding reform, both along the employment lines outlined above, and to avoid the spill-over costs elsewhere in Government. In particular, the well-documented and expensive impacts on NHS services of failures in social care, particularly bed-blocking and avoidable emergency admissions.

5. Paying for Care: Charging, Capping Care Costs and Raising the Means-test

5.1 Carers UK is a member of the Coalition on Charging who have published a detailed analysis of the variation and implications of charging, we endorse their concerns that “current charging levels undermine [social care’s] preventive function as disabled and older people opt out of social care services but their needs then deteriorate with substantially increased costs to the NHS (paid for by all)”.126 However, in addition to presenting barriers to the people they care for accessing services, charging policies can lead to specific challenges for carers.

5.2 Carers UK research shows that nearly two thirds of carers end up spending their own income to pay for care,127 and families often face fear and anxiety because of uncertainty about the costs of care and the possibility of bills totalling tens of thousands of pounds.

5.3 This leads to many families putting off buying care early, because they do not know what the future will hold in terms of care costs. A reticence to invest in preventative support because of this uncertainty can damage family resilience—making it less likely that carers will remain in work and healthy as they can be pushed to breaking point before they invest in support.

5.4 Carers UK believes that the introduction of a cap, as proposed by the Dilnot Commission, would give families the ability to plan for care arrangements and costs and invest in care and support early on. The opportunities for new insurance products opened up by the provision of a cap to cover tail-end risk, would also help give peace of mind, and would encourage and enable families to make plans for care.

5.5 Carers UK also supports the Dilnot Commission’s proposals to raise the means-test for care costs. Families can feel a deep sense of unfairness at losing their savings and assets as a result of care bills. This can be doubly the case for carers who feel that they have worked hard and contributed to the economy throughout their working lives, and made a substantial contribution through caring, yet still face losing the majority of their assets.

6. The Practical and Policy Implications of the Government’s Commitment to Promote Personalisation of Social Care, including Personal Budgets and Direct Payments

6.1 Carers UK believes that Government should continue to drive forward with the principle of a greater choice and control over what happens with care, including in healthcare.

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124 Fairer Care Funding (2011). Commission on Funding of Care and Support p.8
125 Destination Unknown (2010). DEMOS and Scope
126 Coalition on Charging response to this Inquiry
127 Carers in Crisis (2008). Carers UK
6.2 Carers UK’s research has pointed to clear positive outcomes for families personal budgets with 73% of direct payment users saying that the care purchased better met their families’ needs. However carers are also concerned about:

— the burden of administration for direct payments;
— leaving families at risk because of insufficient funds;
— a lack of good quality advice about legal responsibilities; and
— the stepping back of local authorities from their legal responsibilities.

6.3 This points to a clear need for families taking on personal budgets to have access to high quality initial support and training, ongoing assistance with administration and management and brokerage services. As personal budgets are rolled out more widely it is crucial that this kind of good practice keeps pace, rather than greater takeup stretching local authorities’ capacity to support families.

6.4 However the biggest challenge for both families and commissioners in rolling out personal budgets is an anaemic care market which cannot deliver real choice for disabled people and their families.

6.5 Carers UK believes that, as with childcare, there should be a duty on Local Authorities to ensure the sufficiency of supply of social care. There is also a strong role for Government in examining the real drivers and levers which can stimulate the care market, working with local authorities, private sector providers of care, disabled and older people, insurers, employers such as Employers for Carers and the Employers Forum on Disability. International examples of this kind of stimulation, particularly services a la personne in France, have rapidly increased both choice and care standards as well as delivering sustained economic growth.

7. The Barriers Faced by Recipients of Social Care when they wish to Relocate to another Area, Particularly with Regard to the Portability of Assessments

7.1 Carers UK has long argued that a crucial element of social care reform must be the portability of assessments, services and funding so that wherever you live in England, and we warmly welcomed the Dilnot Commission’s proposals around portable assessments.

7.2 Currently carers and service-users face a great deal of uncertainty about what services they will are entitled to according to their area; difficulties in understanding what support is available when the carer and the person they care for live in different council areas; and concern that the services they do have may cease to be funded according to the financial situation of their local authority.

7.3 We currently have the framework and structure for a community care assessment set down by community care law and guidance. The problem is that the guidance is then translated by 150 local authorities to each develop their own. With every new layer of decision-making, new misunderstandings and misinterpretations can be built in which then delivers an imperfect and ill-informed assessment locally. If one is developed nationally, enhancements could be made locally, but the core elements remain national. If there are any local enhancements, then this would need to be made clear so that there is no confusion when a person moves to another area.

7.4 Carers UK is becoming increasingly concerned at self-assessment and Resource Allocation Systems that actively discriminate against disabled and older people and carers by automatically downgrading risk if a carer is present.

7.5 We believe that assessment should be carer-blind. A person’s care needs should be assessed, and there should follow a negotiation about what can be provided by carers and what services need to be provided by the local authority. This way the entire care package can be tailored to support the family as a whole, rather than carers being expected to provide care and then being offered carers services which do not tackle the underlying needs of the family.

7.6 As with the Carers (Equal Opportunities) Act 2004, services should look to support carers’ lives outside caring, rather than simply assist in their caring responsibilities. This would entail services looking at what can be done to support both carers and disabled people to enable carers to work, enjoy a family life, engage in leisure activities and have time for themselves alongside caring.

8. The Practical and Policy Implications of the Government’s Stated Commitment to Promote Integration between Health and Social Care Services

8.1 Carers UK believes that this is considerable scope to improve care and deliver cost savings through better integration of health and social care services.

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128 Carers UK’s 2008 research Choice or Chore surveyed over 600 whose families were using direct payments
129 Choice or Chore (2008). Carers UK
8.2 For example, hospital discharge procedures continue to let down families and result in avoidable costs to both health and care services. Of respondents to a recent Carers UK survey who had been involved in hospital discharge:

— 40% felt that the person they cared for had been discharged too early.
— 31% of respondents saying they were consulted about discharge at the last minute and 34% saying they were not consulted about discharge at all.
— 29% reported readmission within two months and 45% of those believed this resulted from discharge which had been too early.\(^{130}\)

8.3 Hospital discharge is a key moment for families, if done badly with little consultation or planning it can lead to carers being forced out of work as they take on unsustainable caring responsibilities without a supporting care package in place. A lack of rehabilitation can also significantly prolong caring responsibilities as early discharge hinders recovery and the regaining of independence from the older or disabled person. Again, this takes a huge toll on family resilience but can also lead to substantial costs from avoidable readmissions, particularly emergency admissions and early admission to residential care.

8.4 As a result, Carers UK believes that reform must bring a new emphasis on prevention and reablement across health and social care. These services can be very broad—from intensive support following hospital discharge to promote independence, to telehealthcare and lower cost options like building capacity in communities to provide volunteers with support. Care and support commissioners must look beyond traditional service models, to support including telecare and telehealthcare and reablement to deliver on cost savings and outcomes for families:

— Value for money studies show that for every £1 spent on telecare and telehealth, £4 is saved from health and social care budgets from delayed admission to residential care or the prevention of unnecessary hospital admissions.
— ODI reports that on one local authority who, “by spending £37,000 on equipment”, was able to achieve savings of £4,900 per week in respect of residential care for 10 people.\(^{131}\)

8.5 However a lack of pooled budgeting, co-ordination and shared responsibility between health and social care services, and a shortage of strong cost-benefit analysis of the benefits of joint-working hinders this kind of integration.

Carers UK represents the views and interests of the 6.4 million carers in the UK who care for their frail, disabled or ill family member, friend or partner.\(^{132}\)

October 2011

Written evidence from the Local Government Association (SC 66)

About the Local Government Association

1. The Local Government Association (LGA) is here to support, promote and improve local government. We will fight local government’s corner and support councils through challenging times by focusing on our top two priorities:

(a) Representing and advocating for local government and making the case for greater devolution.
(b) Helping councils tackle their challenges and take advantage of new opportunities to deliver better value for money services.

2. The LGA is an organisation that is run by its members. We are a political organisation because it is our elected representatives from all different political parties that direct the organisation through our boards and panels. However, we always strive to agree a common cross-party position on issues and to speak with one voice on behalf of local government. We aim to set the political agenda and speak in the national media on the issues that matter to council members.

3. The LGA covers every part of England and Wales and includes county and district councils, metropolitan and unitary councils, London boroughs, Welsh unitary councils, fire, police, national park and passenger transport authorities.

4. We work with the individual political parties through the Political Group Offices.

\(^{130}\) State of Caring (2011). Carers UK—results based on responses from over 1,700 carers involved in hospital discharge in the last five years, 61% in the last year.

\(^{131}\) “Better outcomes, lower costs” (2007). Office for Disability Issues

\(^{132}\) We are an organisation of carers, run by carers, for carers, with a reach of around 1,500 organisations, including many run by carers, who are in touch with around 950,000 carers between them. Including Carers Week our reach extends to around 4,000 groups and 2.5 million carers.

Carers UK runs an information and advice service and we answer around 16,000 queries from carers and professionals every year. We also provide training to over 2,600 professionals each year. Our website is viewed by nearly 300,000 unique visitors and nearly 1000 carers are members of our website forum. Carers UK has offices in Wales, Scotland and Northern Ireland. This response reflects the views of the organisation, UK-wide.
A Note on our Submission

5. The LGA is pleased to submit a written response to the Health Select Committee’s inquiry on social care and would very much welcome the opportunity to give oral evidence.

6. As per previous LGA submissions to the Committee on adult social care-related inquiries (such as the recent Public Expenditure inquiry) we believe our colleagues in the Association of Directors of Adult Social Services are best placed to explore the Committee’s areas of focus in more practical, “on the ground”, detail. Therefore, whilst our submission broadly follows the Committee’s areas of interest, it is presented as a more strategic, overall commentary on the future of adult social care and support.

Introduction: are we closer to a Reformed System?

Half a Century of Change

7. For almost five decades adult social care has been moving steadily away from the centralised planning and control that characterised the service in the 1960s. From the Seebohm Report in 1968, through to the community care reforms of the 1990s, and more recently with the work of Putting People First and Think Local, Act Personal, adult social care has been taking a more person-centred approach.

8. Today, the goal is to put the individual at the heart of service planning and delivery, joining up the different organisations and individuals within a community that each play a part in either providing services or contributing to an individual’s wellbeing. There is a significant weight of continuity behind this evolution and notions of “choice”, “control” and “independence” are now firmly rooted as defining features of the system we aim to deliver.

9. As social care has evolved, so too has the wider local government environment in which it sits. Particularly over the last 10 years, initiatives such as Local Strategic Partnerships and Local Area Agreements have opened up local public services and encouraged much closer inter- and intra-organisational working. Our world today is as much about local governance, as it is about local government.

10. These dual developments towards personalisation and joined-up services render traditional perceptions of “social care” obsolete. The service should not exist solely as a “welfare net” for those with the severest need or most limited means. Rather, it should be about helping people live their lives as they themselves aspire to, and fostering a sense of collective responsibility for the society-wide benefits of living healthily and planning for the future. This places a responsibility on providers and commissioners alike to broaden their perception of what a person, and communities, may need for everyday living.

11. Evidence that this kind of shift is widely acknowledged can be seen in the simplest sense by noting that “social care and support” has entered the standard lexicon for this policy arena over the last few years. The service—in as much as “service” captures the multiple interactions involved in care and support—is now rightly seen as much for “that little bit of help” as it is for helping an individual wash and dress themselves.

12. As the approach to care and support has changed, we have also seen a concurrent shift in how we view the individual receiving services. Whereas we previously may have described things being “done to” a person, we now see the individual very much as a consumer with increased expectations about the services that should be on offer and the quality of those that are. Informal carers (with their own wellbeing closely linked to the quality of life of the person they are caring for) must also be seen as consumers, experiencing and supporting access to a range of services on offer.

13. This has further cemented the idea that achieving wellbeing is about making use of the whole range of local services, such as transport, housing (which is rightly assuming greater profile in current debates about the future of care), health, leisure and training and education to name a few. It also emphasises the importance of the community and its role in ensuring a sense of universality across both services and consumers who are neither advantaged nor disadvantaged by whether they are publicly of self-funded.

Pressures on the System

14. Whilst we should celebrate the progress made over the last half a century we must also look to the future to ensure the conditions for continued progress are in place. From where we are now—and temporarily setting aside the proposals in the Dilnot and Law Commissions—it is difficult to adopt a confident outlook given three primary issues that are exerting considerable pressure on the system.

(a) Demography: The statistics are well known and do not need repeating here. But in short the system is facing (and is projected to face) significant increased demand as our population ages. To be clear, this is not just a burgeoning population of over-65s and also includes younger adults living longer with disabilities. We of course share Andrew Dilnot’s view that adding years to life is something to be celebrated. But as our primary concern is with adding life to years we flag this as a serious pressure that threatens to undermine continued progress.
(b) **Funding**: There are three high-level observations worth making on funding:

(i) We estimate that in 2010–11 a total of £120 billion of public sector funding was spent on supporting people with a health, housing, disability or social care need. Of this, only £14 billion came from local authority social care budgets. This is not a one-off snapshot and reflects a fairly steady split in how different parts of the wider support system are funded.

(ii) On top of this inequitable ratio, social care funding itself has not kept pace with demand (particularly over the last 10 years). This has inevitably led to short-termism in respect of using the limited levers available to councils to manage demand (principally tightening eligibility thresholds). The net result of this underfunding has been a growing level of unmet need and a consequent increase in the number of individuals that ultimately do qualify for council-funded support by virtue of having “critical” needs. These, of course, are often the most costly.

(iii) In addition to these two funding issues that have developed over time we also need to consider the immediate financial context. Local government as a sector has been hit incredibly hard by the 2010 Spending Review. This set out real terms reductions of 28% in local government budgets over the next four years, and we estimate a funding gap in the order of £6.5 billion for 2011–12. Adult social care is not immune to the impact of these cuts and evidence from the Association of Directors of Adult Social Services suggests that the service’s budget has already been reduced by nearly £1 billion. This makes the relationship between health and social care even more important—particularly given the fact that £1 spent on care services that provide help at home yields bigger savings for the NHS.

(c) **Navigation**: With a range of assessments, means and needs tests, charges, eligibility and interactions with other systems (such as health and benefits) the adult social care system is incredibly confusing for the individual. And as legislation has developed piecemeal over time it is also often confusing for practitioners, with different aspects of adult social care codified in primary legislation, statutory instruments or set out in guidance. This level of complexity in the current system is unsustainable for the future.

15. This is not a definitive list of the pressures facing the current system. But for the purposes of general scene setting they are key issues which, left unaddressed, will prevent future demand being met effectively—by which we mean clear, understandable, appropriately resourced care and support solutions that are tailored to the individual.

**Government, Dilnot and the Law Commission**

16. We are under no illusions that addressing some of the issues outlined above, and securing lasting reform is a major task. Several past attempts—some of which enjoyed considerable momentum—have all failed, exposing the reality that in a debate about state funding, individual contributions and collective responsibility, the long grass is often politically expedient.

17. The question now before us is whether a new attempt—based on the government’s vision and the recommendations of both the Dilnot and Law Commissions—presents an opportunity for reform that may finally be realised. Given the failure of previous attempts it is difficult to predict with certainty how this current debate will play out. But we are clear on three fronts.

(a) First, this is the best such opportunity we have ever had, with clear, workable proposals from both of the aforementioned Commissions, and an apparent willingness from the Leaders of the three main parties to work together toward a solution.

(b) Second, we have a real sense from the sector that we are in last chance saloon on this issue and that failure to reform now will only lead to more major failure just a short way down the line in terms of the system collapsing. With every last ounce of capacity already being squeezed out of the system it is essential that we reform, not preferable or desirable.

(c) We cannot reform the system without increasing the funding for it, and vice versa; the two go hand in hand. To us, funding encompasses a number of different issues that need to be resolved:

(i) Funding the interim period before any reforms are actually implemented to ensure interim increased demand can be met.

(ii) Funding the set up and running costs of a reformed system.

(iii) Funding any shortfall between what a reformed system covers and what costs may still remain.

18. The remainder of this submission explores some of the specific policy implications that stem from the Dilnot and Law Commission recommendations, along with additional commentary on what shape we believe reform should take.

133 We deal with funding in more detail in our written evidence to the Health Select Committee for its 2011 inquiry on Public Expenditure, HC 1499, Ev 64 and 77.
National versus Local: Getting the Balance Right

19. Charges of a “postcode lottery” in care and support have long been aimed at local government. This is a well-supported view (predominantly from user groups) that argues the level and quality of service one receives is based, arbitrarily, on where one happens to live. It is an emotive subject and one that often accompanies the call for a fully national care and support system.

20. We do not believe a fully national system is wrong simply by virtue of being a localist organisation representing local government. Rather, we oppose it on both theoretical and practical grounds.

The Theoretical Argument

21. During the previous government’s engagement process for their Care and Support Green Paper, “many people [said] that they felt it was very unfair that people with the same needs could get different amounts of care and support in different parts of England”. Yet we also know that people want choice and control over the services they receive: “people want better quality services that are personal to them and more control over decisions that affect them. They want the right support, at the right time, in the right place”.

22. Whilst a fully national system would be more likely to remove geographical discrimination from the equation (although one only needs to look to the NHS to see that variation is not always eliminated by having a national structure) it would not pass the test of providing choice and control. These features can only be achieved locally because they depend on a local response to local patterns of need.

23. Taking need first, this will inevitably vary from place to place. It may be about more older people in rural areas suffering from isolation, or the effects of long-term conditions on younger adults in more deprived big cities. And as patterns of need vary, it follows that the response must vary too. This will be shaped by other local factors such as the level of council and partner resources, the infrastructure that supports service delivery, the state of the local care market and local costs. This is local knowledge held, gathered or coordinated by local government.

24. Another theoretical argument for a balance between national and local is based on the public’s preference for service standards being dictated centrally or locally. Sir Michael Lyons local government inquiry included some interesting research on this subject, which demonstrated the public’s clear preference for central standards on “life and death” services (such as the NHS, police, and education), but local standards on services that depended more on quality (such as refuse collection and leisure). The ranking had social services exactly in the middle, with 38% of the public believing standards for the service should be set centrally, and 58% believing they should be set locally. This demonstrates—from the public’s perspective at least—that adult social care is as much about “life and death” as it is about “quality”, which suggests that a balance between national and local is indeed the right approach.

The Practical Argument

25. The practical argument against a fully national system relates to the specifics of how adult social care is funded, and indeed, the way local government as a whole is funded. Despite many people thinking otherwise, funding for social care does not come solely from national taxation. Rather, as the local government finance system is based, in part, on the relative resources a council can draw on, services such as adult social care and support and funded through a combination of central and local funding.

26. We estimate that councils contribute, on average, about 40% towards total expenditure on social care and support, although some councils fund as much as 80%, with some councils spending more on the service than their entire general grant from central government. The main resource councils use to fund adult social care locally is Council Tax, although as different areas of the country have populations with different levels of resource the amount that can be raised locally varies considerably.

27. In a fully national system, the contribution to expenditure from local government would have to be removed from the equation, as it would not be fair to expect councils to raise this money but then have no control over how it is spent. This would raise a number of complex issues:

(a) How would the shortfall (equivalent to more than £5.5 billion) be met? In a fully national system we assume the government would take on this risk, but if it could not manage the shortfall would it then raise a national access threshold? This would refocus the system just on those with the greatest need which, of course, is one of the current criticisms we are seeking to address.

(b) Removing the Council Tax contribution would fundamentally shift the balance of funding (currently about 75:25 central:local) more towards central government. In turn this would curtail local government’s flexibility on local expenditure and would exacerbate the problem of gearing for local authorities—such that councils wishing to increase local spending by, for example, 1% would require much bigger increases in Council Tax to fund it.

135 Putting People First—The Whole Story, Transforming Adult Social Care Programme Board, 2008, p.1
A Design for the Future

28. Adult social care and support is a cash-limited, rationed service. It has been this way since its inception in 1948, although some would go back much further—to the ideas of the “deserving” and “undeserving” poor captured in the Elizabethan Poor Law—to locate its true source. This then, is a system with centuries old foundations, rooted in the idea of a safety net, as opposed to a universal entitlement.

29. The main mechanism for rationing is eligibility and more recent debates about the legality of decisions to set (or change) eligibility thresholds can be traced back to the Gloucestershire Judgement of 1997. This was a complex case in which the court ruled that councils were allowed to take into account their available resources when (a) setting eligibility criteria and (b) deciding whether and how it is necessary to meet assessed needs.

30. The Gloucestershire case highlights a difficult distinction between need and necessity, which plays out today with the vast majority of councils providing services at “substantial” or “critical” (necessity), but not “low” or “moderate” (need). Bearing in mind that the thresholds are fundamentally about the risk of loss of independence to the individual, this distinction can also be viewed as degrees of “survival” and “comfort” which, in some ways, mirrors the “life and death” versus “quality” ranking in the Lyons work mentioned above. If we agree that both are virtuous pursuits for care and support, it follows that the system should seek to provide for both necessity and need.

31. For this reason, and for those set out above, we believe a system should balance both national and local inputs. We summarise these broadly as follows:

(a) National: a portable assessment of need that is acknowledged anywhere in England, along with a portable assessment of an individual’s means.

(b) Local: decisions about the services to meet need, and the amount to pay for them.

32. The Dilnot and Law Commissions adopt slightly different positions on the mechanics surrounding the national/local split. The Law Commission has recommended a national eligibility framework—ie the threshold categories councils use would be set nationally (essentially the status quo)—whereas the Dilnot Commission goes one step further in proposing national eligibility criteria—ie standardised national criteria that means everyone would be eligible if they met, for example, “substantial” or the equivalent thereof.

33. Whilst Dilnot notes the importance of local variation, his proposal for national criteria seems to run counter to the possible expression of it. Although theoretically local decisions could still be made on how to meet need under a system with national criteria, this would require national funding to provide a blanket threshold. In the current climate—and looking ahead to expected increased demand—this seems unlikely, even with the additional money Dilnot’s funding model might bring into the system.

34. Furthermore, there would presumably be difficult distributional issues to resolve. Under a system of national criteria, councils contributing more than the average amount to local expenditure via Council Tax would be covering those that contributed less, so any national system would need to offset any imbalance that existed within it. In short, it would be incredibly difficult to provide portability of entitlement, without a much fairer resource allocation. Additionally, of course, the reality would remain that the assessment of need would still be a subjective process, so variation would likely continue.

35. In our vision of the future, the emphasis is very much on portability of outcomes, with no difference in the ability to achieve those outcomes based along geographical lines. One’s needs (in relation to the risks of loss of independence) are, in the main, identical wherever one lives. But how those needs are met (which means how the associated risks are managed) must be designed locally to take account of the specifics of any given locality.

36. That local response must look both ways; it should draw down from universal services and include, where appropriate, more specific care and support interventions. We view the universal offer comprising services that support a focus on early intervention, prevention and wellbeing. As such this would suggest a shared territory for local statutory and voluntary sector services; a joint endeavour, founded on quality information and advice, to effectively keep people out of the system. We explore these ideas further below.

Personalisation and the Role of the “Social Care Maintenance”

37. It is clear from both the Dilnot and Law Commissions, and the government’s own vision, that the idea of personalised care and support will remain at the heart of any future system. We fully support this emphasis but want to broaden out the definition so it is not just associated with cash transactions.

38. Doing so is important in relation to the group of users who are perhaps the greatest cause for concern: those who seek state-funded services, are ineligible for public funding, yet have very limited means to pay for the care and support they require themselves. For this group, receiving timely and accurate information and advice can be the difference between making poor, costly decisions that ultimately bring them into the state-funded system once their needs have escalated, and good decisions, which maximise their limited resources and maintain their independence. In many cases getting this aspect of care and support right means preventing admissions to residential care, which we know can be a significant cost pressure for the system as a whole.
39. With clear benefits for the individual (in terms of outcomes) and the system (in terms of maximising value for money) what is the best way to develop a system that overcomes any potential obstacles to self-directed support? Away from the specifics of Direct Payments and Personal Budgets, we believe the answer lies in the development of what we are calling “social care maintenance organisations” (SCMO).

40. An SCMO would undertake a brokerage role between the individual, their insurer, and commissioners of care. This is similar to some models of personal budget support, but with a wider role in relation to securing value for money. In this capacity the SCMO would have three distinct roles:

(a) To reduce direct social care costs to a minimum (to the individual, state or insurer) by creative design of support and drawing on collective provision wherever possible.

(b) To secure good outcomes and quality, as well as value for money.

(c) To provide active case management that managed the risk of escalation to emergency or more intensive support, and where feasible sought opportunities to reduce the social care input.

41. In addition, SCMOs could broker the investment by insurers and commissioners in new patterns of service at a collective level that would achieve these goals for groups of users with whom they were working as individuals, were asked to investigate by commissioners, or where there was compelling evidence from elsewhere. These could be developed as user-led social enterprises or other business—from scratch or through diversification from other services. SCMOs would not be direct delivery bodies but rather, personalised intermediaries.

42. SCMOs would therefore occupy the space between place and individual commissioners and insurers. They would be both individual and community case managers and may not need to be wholly new bodies. We envisage them being funded via various routes, including fees from insurers, individual funders, personal budget holders and place commissioners. Given the potential conflicts of interest inherent in their role and the need to put consumers, quality and outcomes to the fore, there is a strong argument for them to be licensed by councils locally, against national or industry standards. Particular attention would need to be given to their role in giving independent financial advice.

Integration

43. Professor Gerald Wistow recently concluded in a paper commissioned by the LGA136 that the NHS and local government operate from hardened silos because that has always been designed into the respective systems. Every change since 1948 has reinforced the two sectors operating in parallel, rather than interdependently, because they are built around the skills of providers, rather than the needs of end users.

44. The White Paper Equity and Excellence: liberating the NHS offered the opportunity for a redesign primarily intended to achieve better outcomes for patients. To achieve this, provider interests would be secondary, with GPs encouraged to shape new patterns of service and given the freedom to pursue quality and diversity of provision.

45. These freedoms are not unconstrained. GPs will have to have regard to the national mandate of the National Commissioning Board and the coordinating role of local Health and Wellbeing Boards. Local government has endorsed the enhanced status of Joint Strategic Needs Assessments and strategies.

46. Most councils have taken the opportunity to press on with establishing these new Boards. They see it as an opportunity to accelerate the horizontal integration of commissioning plans across local public services. However, while local government has advanced, some areas of the NHS have faltered locally. Before the “pause”, some councils were already reporting a loss of momentum as PCTs clustered sub-regionally and key contacts moved on or were lost.

47. Although the Prime Minister’s five promises for the NHS included integration, he has talked more about integration and collaboration within the NHS, rather than across the NHS, public health and social care.

48. Provider interests seem to be hard wired into the proposals and there is a stronger commitment to vertical integration within the NHS. A slow lane for some commissioning groups suggests that national priorities may trump any local plans for those areas. However, optimism may not be completely misplaced and we should recognise how far this process has reached towards its conclusion—particularly given the “in principle” decision represented by Lords Second Reading.

49. The government’s plans encourage commissioning groups to work closely with local government and to plan for whole populations, not just their registered patients. This must also mean scope for full local integration of so-called Cinderella Services.

50. Integration must not be seen as an end in itself and should instead be seen as part of the bigger goal of successful adult social care and support reform. It is important to expose the question to which integration could be the answer and recognise that this may be best achieved at different levels.

(a) Integrated commissioning (rather than top down structural integration) is the key. Health and Wellbeing Boards and their joint strategies are the right vehicle for addressing this, particularly in relation to the so called Cinderella Services where commissioning is multi-faceted.

(b) Services may be integrated in practice by jointly commissioning organisations that can design and deliver services across organisational boundaries. Social care, housing support and children’s services are full of such examples.

(c) For better individual outcomes, integrated personal budgets and better care pathways may be appropriate and sufficient.

(d) The Bill should not dictate structural solutions. It should create the conditions and incentivise integrated commissioning and personal budgets.

A Responsive and Dynamic Market

51. Developing a national guarantee that is expressed locally, such as we have set out above, means we cannot predict how services will adapt and grow under a truly personalised system. We anticipate services may be smaller, more organic, and cross-cutting between, say, health, housing and care. But in a world defined by a delicate balance of people’s own resources, community support, carers and statutory services, the future is not entirely clear.

52. Regulating a market of this kind may well require a different (or additional) set of standards to those we have traditionally applied. Two principles are worth highlighting here:

(a) The sufficiency of supply must ultimately be the council responsibility given its place-shaping function amongst communities and its accountability structures through democratically elected adult services Lead Members and backbench councillors.

(b) Economic regulation must be a robust feature and should incorporate the lessons learned from the recent Southern Cross failure. Whilst this was more an issue of provider failure (and the specifics of the company’s business model) rather than market failure, there is nonetheless learning that can be taken from the experience. This includes, for example:

(i) The need for local, regional and national action if a major care home provider fails (which further emphasises the need for a part national/part local overall model).

(ii) The need to ensure quality in any intervening period between a care home failing and the contingency plan being enacted.

(iii) The importance of evidence and intelligence to identify “early warning” signals that a provider may be in trouble. Securing this local intelligence is a clear role for local government and one of its undoubted strengths.

Concluding Thoughts

53. The Coalition Agreement stated that the government understood “the urgency of reforming the system of social care to provide much more control to individuals and their carers, and to ease the cost burden that they and their families face”.

54. We understand the government’s decision to hold a further period of engagement (“caring for our future”) to ensure that all relevant issues are addressed. We believe this will help address issues of funding and issues of reform, both of which must be dealt with if we are to deliver a system that is fit for the 21st century.

55. But as the Coalition Agreement says, the need for reform is now urgent and we cannot afford any further delays. We need to invest urgently for the short-term, collaborate productively for the long-term, and proceed with all-party consensus. Only this way can deliver for the here and now and for the decades ahead. We urge the current government to go where previous ones have failed to tread.

October 2011

Written evidence from the Association of Directors of Adult Social Services (SC 70)

The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, including the safeguarding of vulnerable adults, ADASS members often also share a number of responsibilities for housing, leisure, library, culture, arts, community services, and increasingly, Children’s Social Care within their Local Authority.
Introduction

ADASS welcomes this Inquiry as an important step in shaping both the Government’s White Paper on Adult Social Care, scheduled for April 2012 and the Integration theme covered by the Futures Forum. This written evidence alongside the oral evidence to be given by Peter Hay, ADASS President sets out the current thinking and positions held by ADASS ahead of the engagement exercises concluding later this year.

Underpinning this evidence, ADASS has developed a set of guarantees on behalf of adult social services to older and vulnerable people which ADASS believes are critical to the success of the White Paper and the widely anticipated reforms of health and social care. These are as follows:

— Freedom from anxiety and the fear of undignified treatment.
— Freedom from financial insecurity in old age, regardless as to whether publicly or self-funded.
— Freedom from a lack of clarity about the social care system.

1. The practical and policy implications of the Government’s plans for funding social care, and the recommendations made by the Dilnot Commission and the Law Commission

— ADASS has warmly welcomed the recommendations of both the Dilnot Commission and the Law Commission and has expressed full support and encouragement that the Government (with full political and sector consensus) responds with a real sense of urgency and commitment (as clearly set out in the Coalition Agreement) to address a long term sustainable funding solution for adult social care and to create a legal framework that is fit for the 21st Century.

— ADASS notes that despite the Dilnot propositions regarding financial certainty, the recommendations themselves do not effectively respond to the widely acknowledged funding gap within social care and the growing demographic cost pressures (widely accepted as 4% per year), as well as responding in an equitable manner to unlocking the £720 billion of equity tied up in housing.

— The Dilnot Commission does acknowledge treating housing assets the same for everyone regardless of where care is received, but its recommendations suggest that this consideration be phased in later. ADASS suggests that there could be an opportunity to respond to the issue of fairness in the treatment of housing assets as a way of generating some of the additional funding that the system needs, after all, people who live in their own homes will benefit from the same cap as those going into care homes. Releasing this equity would provide individuals with “peace of mind” in terms of a means to securing care and support whilst also providing an opportunity to also use this equity for other purposes in pursuit of improved outcomes and enjoyment of life.

— It is widely acknowledged the contribution that adult social care offer makes to the overall health and social care economy, with numerous business cases evidencing the upstream benefits of adult social care integrated activity (focused around early prevention, intervention and increased personalisation) upon the patient pathway and the subsequent costs/pressures within the health system.

— This inter-dependency supports the urgent call for a sustainable and long term funding solution for adult social care which will create the conditions to help the NHS achieve its £20 billion efficiencies whilst maintaining focus upon improved outcomes for citizens and communities.

— Alongside this direct correlation, ADASS also notes the significant contribution that adult social care has upon the economy, with the sector employing more people than the NHS and it is expected to grow in response to increased demographics and the continued expansion of personalisation. This contribution has been widely underrated and adds to the business case for a sustainable and long term funding solution.

2. The scale and implications of existing variation in access to and charges for social care in England

— The ADASS Budget Survey accurately portrayed the distribution of the Fair Access to Care (FACs) criteria being applied by the 152 English councils. This distribution highlighted that the majority of councils were operating at substantial or above levels (82% of councils in 2011–12) and that 13% of councils changed their eligibility criteria in 2011–12.

— Despite this increasing drift towards higher eligibility, ADASS recognises that the biggest implication upon variation in accessibility pivots around the antiquated social care legal framework, alongside current dynamics of increased personalisation and numbers of self funders outside the system and variations in market supply. In response, ADASS supports the reforms of the legal framework in tandem with localised decisions as well as closer integrated working towards market development and commissioning to secure a flourishing and diverse offer responding to all citizens needs and improved outcomes.
— Indeed it is recognised that many councils (in partnership with health) have put in place effective health and wellbeing strategies (centred around prevention and early intervention) which proactively seek to empower and support individuals in maintaining independence in their own communities without recourse to FACs services and support. The success of these approaches is well documented but it is also an area which there remains variation in how councils and partners interact with self-funders. This is something that ADASS is addressing head-on through sharing good practice and exploring models of integrated working ie the recently launched ADASS Efficiency Network and the ADASS “Managing Resources” workstream.

— The ADASS Budget Survey confirmed that councils had increased charges by a total of £84 million in 2011–12, but this needs to be seen in the context of the overall reductions made by Adult Social Care Departments, with increased charges only equating to 8% of the reductions compared to £681 million (69%) secured through improved service efficiencies. This clearly demonstrates the extent by which councils sought to protect front line services through local democratic decisions responding to local conditions and political mandates.

3. The practical and policy implications of the Government’s commitment to promote personalisation of social care, including personal budgets and direct payments

— ADASS fully supports the personalisation offer and has been the champion of personalisation within the public sector, leading the way on personal budgets and direct payments over the past few years.

— ADASS sees personalisation as an essential building block towards the case for change, creating a new and exciting space in which individuals can truly experience choice and control matched with personal responsibility.

— ADASS has worked closely with the Government to develop and refine the personalisation offer and all councils have committed themselves to meet the Government target of all eligible social care clients to be in receipt of personalised budgets/direct payments by March 2013. Indeed the latest survey conducted by Think Local Act Personal indicates that councils are well on track to meeting this target.

— As part of the adult social care commitment to sector-led improvement, ADASS surveyed councils this year to establish the extent of progress towards personalisation and to establish some of the key challenges and successes that councils can learn and benefit from. These are detailed below as follows and provide a useful reference for development work across the sector and with Government moving forward:

1. Most councils lack the evidence base for the cost effectiveness of advisory and brokerage support services, though indicators for outcomes are well articulated.

2. There is proactive investment in communication plans, staff training and development to ensure that individuals are aware of the universal offer.

3. Some councils encourage a positive risk-taking culture, but there was a paucity of information on mitigating measures.

4. Financial accounting capability to individual levels is patchy. Whilst trying to achieve fully integrated accounting systems some respondents felt these pose both challenges and risks to the service.

5. Some council do not fully understand market development and confuse market analysis with market shaping. The spectrum of market activity is broad, but the majority of councils are stimulating new models, whilst some are encouraging new market players. It is noted that this council viewpoint on the supply and range of personalised support needs to be checked against the perception of service users

6. Some council have not extended brokerage and advocacy services to self-funders.

— Central to personalisation is the focus upon improved outcomes and ADASS has worked closely with Government and across the sector to develop the integrated outcomes framework as a means to articulate these outcomes as markers of performance and progress. The alignment of outcomes and personalisation creates a powerful dynamic towards real citizen choice and control and a means to create an integrated response. Although this framework has been well described, the next challenge is to ingrain the framework fully within the commissioning activity across the sector.

— The balance between increased personalisation and the numbers of self funders is driving new challenges regarding both the availability of reliable and accessible information and advice, set against a responsive market place. Councils have positively responded to this challenge but this remains an issue which requires continued development and meaningful engagement with self funders to address variation in approaches.
4. The barriers faced by recipients of social care when they wish to relocate to another area, particularly with regard to the portability of assessments

— ADASS fully supports the portability of assessments and the work upon creating a system based upon improved outcomes combined with anticipated reforms of the legal framework and a fair and equitable funding solution that will create the environment in which individuals can enjoy real choice and control.

— In terms of current barriers the current legal system lacks clarity, the current funding system does not effectively respond to local demographic/socio-economic needs and the level of market sophistication varies from place to place. These elements combine to create a toxic mix of inconsistency and variation.

— ADASS also recognises that the welfare system itself often penalises or restricts individual movement and any reforms to the social care system must also be undertaken in synergy with welfare reforms to create incentives to allow for individual movement.

— Alongside the work of councils in market shaping, ADASS argues that the reformed system should be balanced with a national portable assessment of need that is acknowledged everywhere along with a portable assessment of individual means, but that there remains local democratic decisions about the services to meet need and the amount to pay for them.

5. Economic regulation of the social care system including a proportionate failure regime that can mitigate against the failure of social care providers

— ADASS has already commented to Government through its responses to the Care Quality Commission consultation on regulation and to the Health Select Committee Inquiry on the Regulators as to addressing economic/financial regulation of the social care system.

— ADASS notes that there is a pressing need for public assurances on the financial fitness of care providers—as evidenced by the recent collapse of a major provider group and its unsustainable business model. This is a key question for the adult social care sector as a whole and requires a response which allows for transparency and clarity at every level.

— In response, ADASS seeks clarity as to how the regulatory function of Government can assist in this public reassurance, whether this be the role of the Care Quality Commission or Monitor in confirming the financial fitness of operations (NB the proposed CQC Registration Framework does not mention “financial fitness” in it’s criteria) and would seek commitment from the Regulators as to their visibility and level of engagement with providers with regards to compliance with the regulatory framework.

— Secondly, ADASS is encouraging the (provider) sector itself to offer greater public transparency through the availability of consistent and accessible financial information. The Association ADASS is already working closely within the sector to seek these reassurances (for example Think Local Act Personal- “Making it real”) with particular reference to robust and accessible information and advice that drives more “informed” decisions by citizens. This is particularly important at points of crisis when they may first interact with adult social care.

6. The practical and policy implications of the Government’s stated commitment to promote integration between health and social care services

— ADASS supports and is fully committed to the reforms of health and social care. This is great opportunity to bring forward further integration of services and support around people.

— This is a central theme of the proposed reforms of health and social care and fundamental to creating a system that responds effectively and efficiently to improved outcomes for individuals and communities.

— However ADASS does not necessarily believe that integration is purely about changing structures or bureaucracy, but is equally about culture, behaviours and values, particularly introducing the social model of care into more wider fields.

— ADASS believes that any integration must be bottom up rather than purely just England—wide prescribed structural reform. The dynamic of localised commissioning provides the vehicle for real integration which is referenced against a localised JSNA and articulated as a local Health and Wellbeing Strategy, subject to local democratic scrutiny and endorsement.

— Indeed ADASS has constantly maintained that it is the Health and Wellbeing Boards that hold a major key to integration and the proposed reforms must ensure that these Boards have the necessary statutory leverage to bring partners together around a set of agreed priorities and outcomes and that these arrangements ensure transparent democratic local accountability, best served by local government.
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— ADASS acknowledges that these reforms bring new challenges and opportunities and the new reformed world needs to balance how both individual and public money works together and how different elements of the NHS, GPs, Public Health and Local Authorities combine to provide the variety of the universal offer set against local conditions. Indeed ADASS states that “we must be clear about trying to impose national structural solutions to integration, as opposed to building the conditions together that remove the gap between health and care around people in whatever way makes most sense locally, and in a way that works and can be held to account.”

October 2011

Written evidence from the NHS Confederation (SC 74)

Introduction

The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation that represents all types of providers and commissioners of NHS services.

We speak for the whole of the NHS on the issues that matter to all those involved in healthcare. We also reflect the diverse views of the different parts of the healthcare system.

1. Executive Summary

1.1 The NHS faces an exceptional financial challenge, exacerbated by rising demand for care from an ageing population and the longer-term survival of children and adults with complex needs and disabilities. The challenge can only be met if health and social care work in an integrated way to ensure high quality care is commissioned and delivered in the right place at the right time.

1.2 Pressure on local authority budgets is already having an impact on NHS services. In a major NHS Confederation survey of some 287 NHS chairs and CEOs, three quarters of respondents (75%) said cuts in local authority spending would definitely impact on their services in the next 12 months, predicting increased demand for community, mental health and primary care services. They also predicted increases in delayed discharges from hospital, acute admissions to hospital, emergency readmissions to hospital and A&E attendances.137

1.3 If a sustainable solution for funding social care is not found, the NHS will buckle under the pressure of demand—particularly for emergency and unplanned work, and delayed discharges. The Dilnot Commission’s proposals are the most credible and practical solution on social care funding for some time. The lack of a clear response from the Government to Dilnot’s proposals is very unhelpful. It is critical that the Government commits now to a clear implementation plan in response to the Commission’s recommendations.

1.4 It is important that the public faces up to the true costs of providing social care. In implementing the Dilnot Commission proposals sustainably, it will be essential that:

— Politicians, the Government, NHS and local authorities are honest about the scale of contributions the public will be liable for in future.
— Clear information is made widely available, so people can make provision for this.
— The system is designed in such a way that the different rights and responsibilities of individuals and organisations within health and social care are clear to the public.

1.5 To meet the changing needs of patients, we need to redesign models of health care and integrate them with social care in one comprehensive offer. This means coordinating care from a range of providers around the needs of patients. It does not automatically require organisations to be restructured or merged. The focus should be on integration as a means to a better patient experience and improved outcomes and this should be how success is measured.

1.6 Health and social care services need to be considered at a national level as “two sides of the same coin”. While integrated working needs to be driven locally, it is essential that co-operation between health and social care is championed and supported much more proactively at a national level.

1.7 Many local instances of integrated working exist, delivering real benefits for patients. However, organisations seeking to work in an integrated way must overcome significant barriers including: payment systems which often reward individual organisations for the amount of activity they undertake and can also prevent sharing of the financial savings delivered through joint working, conflicting measures of performance, and the need to build and maintain strong working relationships across a range of organisations. Supporting and enabling more widespread integrated care will require:

— CCGs and local authorities to develop appropriate local arrangements, which may include joint budgets.

— Appropriate tariff or other payment mechanisms to support integrated working across organisations.
— Mechanisms to allow organisations to share the savings made from collaborative working.
— Closer alignment of outcomes frameworks and clarity about how joint accountability for outcomes will work in practice.
— Health and wellbeing boards, as the key mechanism for monitoring and supporting integrated working, must ensure they play a role in bringing together NHS and wider local government services, such as housing.

1.7 Suggestions that Any Qualified Provider (AQP) is incompatible with integrated care are wrong. When using AQP, commissioners should incorporate contractual requirements to improve integrated care and cooperation. A tariff system for integrated services is also required.

1.8 We strongly welcome the emphasis on increasing personalisation and empowering patients/service users with their own budget. Our Mental Health Network’s recent research set out five tests which we believe should be applied to any strategy to extend personal health budgets beyond the current pilots, to ensure they work for service users:
— Has the national evaluation generated evidence that personal health budgets improve outcomes, experience or cost?
— Does the roll-out establish guidance for a significant expansion of the brokerage and advocacy systems?
— Has a viable solution been found for how to release funds to finance personal health budgets at scale?
— Have sufficient preparations been made to integrate personal health budgets in the NHS with personal budgets for social care?
— Does the plan to roll out personal health budgets contain sufficient levers to drive take-up?

2. The Current Funding Position—and Implications for the NHS

2.1 The NHS faces an exceptional financial challenge as it responds to increasing demand for its services, an ageing population, above-inflation increases in NHS costs and implementing major structural reform. The NHS must also realise up to £20 billion of efficiency savings by 2015 to continue delivering high quality services (the so-called Nicholson Challenge). This will require unprecedented productivity savings of at least four percent a year across all NHS organisations.

2.2 This challenge has been intensified by other public spending cuts, not least cuts in local government budgets. Adult social care is the largest service area funded by councils. It generally forms approximately 35% of the spending that councils have control over (as opposed to things that are paid directly to schools and other institutions) and sometimes more. Given the significant reductions in local government funding over the Comprehensive Spending Review (CSR) 2011–14 period it is hard to see how the full range of social care services can be maintained, despite the sensible decision in the CSR to allocate £1 billion from the NHS budget to social care. The effects on healthcare are likely to be greatest in areas of high deprivation, notably inner cities where health outcomes are already poor. The local government settlement affected these areas severely and this effect has been exacerbated by the loss of specific grants to councils, which had been paid where health needs were highest.

2.3 Both the NHS and local government are very aware that we must avoid cuts which simply result in shifting costs from the local authority to the NHS and vice versa. However this is still happening in some places, for example, members of our Mental Health Network already report growing numbers of local authorities withdrawing from integrated older people’s and other adult services. We are concerned that as financial problems become more profound, it will become harder for individual organisations to look outwards and invest in cross organisational collaborations that deliver more efficient, more integrated, better patient care.

2.4 In a major survey of some 287 NHS chairs and CEOs, the NHS Confederation asked for views about the impact of cuts in local authority spending on the NHS over the next 12 months. Three quarters of respondents (75%) said these would definitely impact on their services, while 85% said the issue would be problematic and 24% said it would be “extremely problematic”. The vast majority predicted an increase in demand for community (88%), mental health (72%), and primary care services (71%). They also predicted increases in delayed discharges from hospital (86%), acute admissions to hospital (63%), emergency readmissions to hospital (63%) and A&E attendances (55%). 51% of respondents listed cuts to local authority budgets as one of the top three barriers to them to meeting QIPP or Cost Improvement Programmes.

2.5 Where funding reductions in social care mean people’s need for care is not met, they will turn to the NHS, thus increasing further the demand for NHS services. In particular, this will mean increasing numbers of unscheduled emergency admissions to hospital, as well as delayed discharges where community based.

integrated health and care packages are not available or not sufficiently comprehensive to ensure independence can be maintained in the person’s own home. Evidence from the NHS about increasing numbers of delayed discharges is clear. Department of Health figures showed that delayed attributable to the NHS with the reason “awaiting public funding” are 21% higher, while for social care it is 26% lower.

3. The Dilnot Commission Recommendations

3.1 Pressures in both the NHS and social care will only get worse, in terms of the funding settlement for each, the demographic pressure of an ageing population and increasing numbers of people surviving long term with complex care needs. While funding has been transferred from the NHS to social care to help cover the transitional funding gap, this is not a long term solution given the pressure on NHS budgets and the rising demand for services. If a sustainable solution for the funding of social care is not found the NHS will buckle under the pressure of demand—particularly for emergency and unplanned work, and delayed discharges.

3.2 The NHS Confederation therefore welcomed the report of Professor Andrew Dilnot and the Commission on the future funding of social care and we endorse the underpinning principles of portability, personalisation, integration and universality. We feel the proposals are the most credible and practical solution on social care funding for some time. They could provide a basis for a sustainable model for funding for social care and in particular we welcome the recognition that a voluntary funding model will not work.

3.3 There is a need for a universally accessible and funded system of care that includes a core and consistent offer of service, potentially along the lines of the NHS Constitution. In an NHS Confederation report published in 2008, we suggested some key principles which we believe remain relevant to the delivery of a sustainable social care settlement. These included:

- A national social care benefit package, enabling a standard minimum entitlement.
- Cost sharing between individuals and the state.
- Pooling social care funding with relevant areas of health resources and benefits to provide a unified personal budget.
- An adaptation of the partnership model developed by Prof. Derek Wanless which would help to safeguard assets and eliminate any disincentive to save for care whilst alleviating concerns about the affordability of additional care costs.
- A social insurance top-up partnership, with consideration given to making this compulsory for all except the most wealthy members of society with the poorest receiving tax funded top ups.
- Individual choice provided through the insurance plans.
- A new role for social care commissioners in light of changes such as individual budgets and a minimum entitlement.

3.4 A major problem with current social care funding is the lack of consistency between different local authorities on what support is covered and when help can be provided. A nationally consistent system, with an assessment which follows the service user wherever they move, would ensure that when people access services their needs were considered in a consistent way wherever they lived and would reduce the number of assessments to which they and their carers were subjected.

3.5 Much will still depend on eligibility thresholds for free NHS continuing healthcare and the levels at which both the contribution cap and the means testing thresholds are set. We believe that the inconsistency between fully funded NHS care and means tested social care can both confuse users and hamper the delivery of a comprehensive care package supporting care closer to home. Indeed it may even act as a disincentive for people to find their own solutions to funding care on a long term basis. Until this inconsistency is addressed by the Government there will be an inherent tension which will make the delivery of successful integrated health and social care difficult to achieve. The NHS Confederation continues to have reservations about the alignment of the system set out by Dilnot with free NHS continuing healthcare assessment and funding, which will not be alleviated purely by recasting continuing healthcare as a personal health budget. We recommend that the Government ensures the social care system is designed in such a way that the rights and responsibilities of individuals and organisations are clear to the public.

3.6 Giving individuals some certainty about their personal liability would better allow those who are able to plan how to meet the costs of care up to the proposed cap. However, we stress that the Dilnot Commission’s proposals are still complex in some areas, for example on how accommodation costs are paid and the factoring into state entitlement assessments of informal care contributions. To ensure that the current confusion about eligibility and uncertainty about liability are not transferred to the new system, we call for:

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--- greater honesty from politicians, the Government, NHS and local authorities about the scale of contributions which the public will be liable for in the future.
--- clear information to be made widely available, to support individuals in making decisions about the most appropriate funding plan for their needs.

3.7 It is critical that the Government now sets out a clear response to the Dilnot Commission recommendations, including a clear plan and date for implementation. We also want the Government to outline as a matter or urgency how it will raise the additional central funding for social care estimated by the Commission, £1.3–2.2 billion. The Government needs to make a decision on this as soon as possible, with due regard to the existing pressures on the rest of the public purse.

4. Achieving Integration between Health and Social Care

4.1 People with long-term conditions are major users of the NHS. Greater life expectancy means patients can typically have several long-term conditions. One of the most challenging of these is dementia. 70% of acute hospital beds are occupied by older people, 20% of acute beds are occupied by people with dementia and 75% of residents of care home have dementia. For many of these people, day to day care is provided through social care, either through councils or by people arranging their own care directly. Increasingly these forms of care will merge as the use of personal budgets increases. The NHS should recognise the need to redesign its models of care around frail people living with chronic illness in community settings. This approach must be integrated with social care in one comprehensive offer, which is easy to navigate for patients.

4.2 The Nicholson Challenge further strengthens the case for redesigning care. Care will need to be provided closer to home and early intervention and self care will need to increase. These major changes must be delivered in full partnership with social care and other local authority services, such as housing, without delay.

4.3 The NHS Confederation believes that health and social care integration can be achieved locally by focusing on:
--- outcomes rather than targets—the proposed statutory joint health and wellbeing strategy provides an opportunity to develop joint local plans to achieve shared outcomes;
--- cultures not structures—integrated working is not solely about organisational mergers, as these can create fragmentation between new organisations and other services. Integrated working can be better supported by ensuring professionals in different organisations have a good understanding of the other parts of the system. This will enable different organisations to work together more easily;
--- place not organisation—bringing together all local public services through health and wellbeing boards will support further progress on integrated working; and
--- delegation not transfer of functions—this can avoid power struggles that often result from more formal arrangements.

4.4 We also believe that clinical and professional engagement and mixed professional teams will enable further improvements in integrated working. Where bottom up joint working can be linked to good supportive local leadership this can drive change in front-line services.

4.5 While integrated working needs to be driven locally, it is essential that this is championed and supported more proactively at a national level. This must include:
--- national bodies such as the NHS Commissioning Board and Monitor working to create the conditions to enable health and social care professionals and leaders to drive change locally;
--- a more co-ordinated approach to policy development between health and social care nationally; and
--- closer alignment of the outcomes frameworks for the NHS, public health and social care.

4.6 The benefits of health and social care integration will need to be measured to ensure it brings benefits to patients and improves quality of care. The NHS Confederation recommends CCGs, local authorities, the NHS Commissioning Board, Monitor and NICE work together to collect evidence to demonstrate the benefits of integration on patient care. The Government will need to agree how to measure and further develop the evidence base.

5. Overcoming Funding Barriers

5.1 Current funding models are still not aligned between the NHS and local authorities. This means that savings made through the actions of one service can accrue to another with no easy route for sharing the savings between them. This disincentive to collaborative behaviour is particularly significant given the extreme financial pressures on individual organisations, and could become even more significant as a more competitive NHS market environment develops.

5.2 The current tariff system that pays the health service per activity (Payment by Results) does not cover care across a whole pathway or incentivise action on prevention and early intervention. Tariff rules are often found to be bureaucratic, run counter to co-operation in the system and fail to reward the right sort of

6. Importance of Local Relationships

6.1 A report jointly produced in 2010 between the Association of Directors of Adult Social Services, the Department of Health and the NHS Confederation, based on a survey of local partnership arrangements, highlighted that strong local relationships, trust and a shared culture and vision were seen as very important in facilitating joint working and integration. The survey also showed that openness about shared financial issues, which involves considerable time and effort.

6.2 It is unfortunate that the re-organisation within the NHS has fragmented existing relationships particularly as PCTs cluster and co-terminosity with local authorities is lost (albeit in the short to medium term). Though people within the health service are positive about the potential role of local Health and Wellbeing Boards in bringing together the local health and social care systems, in the interim relationships will remain fragile and this could make it harder to ensure patients get their care delivered in the most appropriate place at the right time.

7. Implications of Changes to Commissioning Structures

7.1 We welcome the government’s increased emphasis on integration in the Health and Social Care Bill 2011. Connecting services across a whole pathway across health and social care will not only improve quality of care but also result in efficiency savings. We are pleased that CCGs and the NHS Commissioning Boards have duties in the Bill to promote integrated health and social care, clinical senates will include experts to support better integration of services and Monitor (previously solely an economic regulator) will be required to support delivery of integrated services where this improves care or efficiency.

7.2 The reforms currently propose that, in many areas, services will be commissioned by multiple bodies, namely local authorities, the NHS Commissioning Board at national and sub-national levels and Clinical Commissioning Groups (CCGs). We feel this could make coordination of integrated care more complex, and could potentially lead to fragmentation of care, with services for a single individual with multiple conditions potentially delivered by a range of providers working on different geographical footprints. We therefore strongly urge the Government to be explicit about which parts of the system are responsible and accountable for commissioning adult health and social care and how joint accountability for shared outcomes between the NHS, social care and public health outcomes frameworks will be monitored, measured and incentivised.

7.3 To further support integration between health and social care in the reforms, and help prevent the progress made over recent years in integrated commissioning from being lost, the NHS Confederation’s recommendations include:

- Integrated commissioning may be more complicated than in the past, due to multiple commissioning bodies (CCGs, local authorities and NHS Commissioning Board). We suggest one locally determined organisation should lead integrated commissioning arrangements for their local area.
- It will take time for professionals to work in more integrated ways across multi-professional boundaries. Monitor should allow CCGs and local authorities to develop locally appropriate solutions to strengthen integrated working.


8.1 The Bill establishes Health and Wellbeing Boards to promote coordinated planning across NHS, public health and social care services. Health and Wellbeing Boards have a duty to encourage integrated working across health and social care services. Bringing local government and health together on Health and Wellbeing Boards should help to enhance understanding of the available resources locally and improve the engagement of communities and stakeholders. The NHS Confederation with other national representative organisations and the Department of Health has developed operating principles for Health and Wellbeing Boards and which we hope will support closer integrated working at local levels.145

8.2 Health and wellbeing boards will have to monitor integrated working between health and social care and ensure local needs are incorporated within the Joint Strategic Needs Assessment and addressed in the joint health and wellbeing strategy. We recommend that a specialist subgroup of local Health and Wellbeing Boards should be established to encompass responsibilities for commissioning integrated services.

8.3 Care closer to home should include a wide range of approaches involving more than just the integration of NHS and social care services but including housing, transport, leisure and welfare services. We therefore also recommend that health and wellbeing boards should play a role in bringing together NHS and local government services such as housing, transport, leisure and welfare.

9. The Implications of Any Qualified Provider (AQP)

9.1 It would be wrong to suggest that the Any Qualified Provider (AQP) policy is incompatible with delivering integrated care. However, it is not yet clear how the policy will impact upon services when implemented and there may be unintended consequences. We understand that in one area an NHS trust has pulled out of an integration agreement with their local authority as they had taken the view that their integration plans for collocating teams across health and social care organisations were not conducive to the delivery of AQP.

9.2 The Department of Health requires primary care trusts to identify three or more community or mental health services in which to implement AQP 2012–13, such as continence or podiatry services. These services are in high demand and if supply goes up, levels of referrals will need to be monitored to ensure needs are met and services are not over subscribed. The services that have been highlighted for AQP are closely connected with social care and other services. Therefore the NHS Confederation recommends that when commissioners use AQP policy for services they should incorporate requirements in providers’ contracts to improve integrated care and cooperation with other providers in the care pathway. Similarly Monitor could include a requirement for integrated working (eg sharing of information) in its licensing regime. A tariff system which supports integrated services is also required.

10. Personalisation

10.1 We welcome the emphasis that has recently been placed on increasing personalisation across health and social care. This has several potential benefits including:

— enhanced control and empowerment for service users;
— more choice for users in the delivery of care;
— making complex service packages more effective;
— the capacity to speed up and enhance service redesign, driven by service users; and
— the opportunity for a single integrated experience of care.

10.2 Personalised health and care packages can help make the provision of care clearer and more coherent and will devolve rationing decisions down to the individual. However, we believe safeguards need to be in place to ensure that this does not become overly burdensome for the user or their family carers.

10.3 There could also be a lack of oversight of the quality of some services individuals may purchase, as some may not automatically be covered by CQC registration standards. We believe that more needs to be done to ensure that the regulatory system retains the oversight of quality in these cases. However, the capacity for service offers to be produced by individuals in partnership with social care organisations should improve innovation and encourage new and different providers into the care market.

145 Operating principles for Health and Wellbeing Boards: laying the foundations for healthier place http://www.nhsconfed.org/Publications/reports/Pages/Operating-principles.aspx
10.4 The NHS Confederation’s Mental Health Network has published a series of briefings which look at the implementation of personal budgets. We are concerned that there is not currently sufficient confidence or consensus in the system to roll out personal budgets within the NHS with much momentum. Without steps to address these cultural and practical issues, personal budgets risk failing to deliver on their potential. Our report\textsuperscript{146} proposed five tests which we believe should be applied to any strategy to extend personal health budgets beyond the current pilots, to ensure they work for service users:

- Has the national evaluation generated evidence that personal health budgets improve outcomes, experience or cost?
- Does the roll-out establish guidance for a significant expansion of the brokerage and advocacy systems?
- Has a viable solution been found for how to release funds to finance personal health budgets at scale?
- Have sufficient preparations been made to integrate personal health budgets in the NHS with personal budgets for social care?
- Does the plan to roll out personal health budgets contain sufficient levers to drive take-up?

\textit{October 2011}

\textbf{Written evidence from SHIP Equity Release (SC 75)}

\textbf{Executive Summary}

- SHIP is the UK trade association for responsible providers of equity release products. Launched in 1991, SHIP is dedicated to upholding a strict code of conduct for its members that is designed to protect consumers and ensure safe, regulated growth of the industry. SHIP now represents around 90\% of the UK equity release market.
- SHIP was formed to create a safer and more secure market for people considering releasing equity from their homes and SHIP continues to promote and develop its code of conduct for equity release providers.
- SHIP welcomes the recommendations made by the Dilnot Commission and the Law Commission and has called on the Government to implement these proposals forthwith. SHIP is particularly encouraged by the Commission’s call for the Government to establish a working group of “central government, local government, the financial services industry, the Financial Services Authority and interested third-sector organisations”.
- For some time SHIP has argued that in order to better understand the needs of people in retirement and those requiring care, the Government should establish a cross-industry working group to help the equity release industry, and other financial services sectors, design products that can meet people’s need in an environment that offers a degree of certainty.
- SHIP would also like to see the Government adopt a clear position on equity release by acknowledging that for some people it is a viable option for social care funding. There will also be a need to define departmental responsibility for the innovative products developed by financial services providers to help fund social care, including equity release products.
- SHIP has noted with interest that this inquiry will look at the practical and policy implications of the Government’s plans for funding social care and the recommendations made by the Dilnot Commission and the Law Commission. In this respect, SHIP’s comments in this submission relate to the funding of social care and the role the Government and the financial services industry has in delivering proposals for social care reform.

\textit{The existing system}

1. SHIP considers that one of the main problems with the current social care system is that it is overly complicated and difficult for people to assess what support is available to them. In particular there are complexities in how benefits interact with financial services products, so that people wishing to access funding to provide for themselves are unable to fully understand how doing so would affect the support that they are entitled to.

2. For example, if people have equity in their property their benefits are unaffected, but if a person releases equity from their property, they may find that it impacts upon certain benefits, such as the pension credit, although it is often unclear and difficult for people to understand under which circumstances this would be the case.

3. There is a scarcity of reliable, independent information to help people approaching, or in retirement to understand the system, which has contributed to there being little public understanding of social care access, charges and the financial options from which they can choose. People face substantial difficulties in accessing

advice and understanding about the products that already exist such as immediate needs annuities and equity release.

4. This lack of understanding has caused a shortage of demand for financial products because consumers simply do not think they need them, considering them as an emergency purchase. Similarly, there is a lack of incentives to plan ahead and if the market is ever changing, people will be more inclined to accept the risk of being the one in four people who will need to depend on long term care.

The future funding of Social Care

5. SHIP welcomes the Dilnot Commission’s recommendation of a partnership model where the burden of the cost of care is shared between individuals and the state, but where individuals are insulated from the risk of incurring very high care costs.

6. A more simplified, coherent system, with nationally consistent eligibility criteria, would create an environment where people felt more comfortable exploring the role of financial products in supporting the cost of care.

7. However, SHIP would caution that there has been some concern that the Dilnot report has caused more confusion about costs, particularly in relation to how the £35k cap has been presented and relates to residential costs. In particular, there needs to be more clarity around the expected level of residential costs and what people will be obliged to contribute. Furthermore, this will be subject to a means test so there will not be one clear cost that can be communicated to people, instead depending on the quality/level of care people demand, their means and what their local authority provides. If this is oversimplified, customers may feel a false sense of security around the level of their financial contribution and lead to a feeling that there is no need for advice.

8. Similarly, there needs to be more clarity about what costs and purchases count towards meeting the £35k cap. For example, there needs to be further discussion around whether this will include preventative measures such as property adaptations or simple tasks such as gardening.

Use of housing equity to fund long term care

9. In order to contribute to the partnership model suggested by the Dilnot Commission, individuals will increasingly need to have access to a range of assets. We believe that it is essential that equity release is presented by the Government as one of the range of options for funding long term care given.

10. Analysis from the Pensions Policy Institute estimates that there is £250 billion of available equity for release immediately, highlighting the level of untapped housing wealth in the UK which is held among the “at” or “near” retirement generation. Separately, ONS figures show that more than two thirds of over 65s are homeowners without a mortgage. However many are dependent on modest incomes and/or state funds for retirement. This means that, while they might be described as asset rich, they are often cash poor and unable to fund their care and support.

11. These statistics suggest that equity release will be one of the methods by which an increasing number of people may choose to fund their social care. For many, housing equity will be the most viable financial asset on which they can depend for long term care purchases.

12. However, currently people do not know what options are available to them, it is not clear to them what contribution they will need to provide and they do not know enough about the different financial options that might assist them.

13. The Government should acknowledge that equity release can be a mainstream solution for some people to fund long term care. However, there is at present an unhelpful message that advisers should come under excess or extra scrutiny when advising on equity release because it is not a mainstream product but one of last resort. The present negativity surrounding these products should be eradicated and the regulator should be encouraging advisers and providers to enter the market.

14. SHIP is adamant that there is a need for customer safeguards and guarantees, such as those provided by the SHIP Code of Conduct. This includes a no negative equity guarantee, so that people will never owe more than their home is worth, even if their home significantly reduces in value. SHIP is also supportive of better regulation to offer greater consumer protection. The creation of a cross-industry working group, liaising with the Government and the FSA, will enable all interested stakeholders to more effectively consult on the principles that underpin the regulation of these services.

15. SHIP is confident that equity release, as one of a range of innovative financial options, will offer greater choice to consumers for how they wish to fund, and consequently how they receive, social care. SHIP recognises that equity release is not the right option for everyone; however, many people will consider it the right option for them and it is important that it is presented to people as a viable option to consider.

Access to Financial Advice

16. SHIP is encouraged by the Dilnot Commission’s recommendation that the Government invest in an awareness campaign to encourage people to plan for later life, along with a “major new information and advice
It is important that this information comes from the Government to ensure that those receiving it understand that the advice is impartial and that there are no misunderstandings about vested interests.

17. A new information and advice strategy would tackle this problem if delivered correctly. SHIP would suggest that the Government should produce a guide or information pack to be distributed to people as they approach retirement, possibly as an expansion of the brochure that the Department of Work and Pensions currently distributes to people who are nearing their retirement date. The pack should include unbiased and independent information for people about the various options for them in terms of retirement and social care funding, including the types of financial services that are available.

18. SHIP would also endorse the findings of the Law Commission report which emphasised that local authorities have a duty to inform, to advise and to assist all residents, not just those who depend on state help. It is of paramount importance that all people have access to financial advice as they are approaching or in retirement. The local authority, and potentially care providers, should be obliged to recommend to self-funders that they obtain financial advice from appropriate qualified advisers.

October 2011

Further written evidence from SHIP Equity Release (SC 75A)

SHIP Equity Release

SHIP is the UK trade association for responsible providers of equity release products. Launched in 1991, SHIP was formed to create a safer and more secure market for people considering releasing equity from their homes and continues to promote and develop its strict code of conduct for providers. These guarantees include a no negative equity guarantee which means a lifetime mortgage can never roll up to more than the value of the customers home, we also insist on a fully advised sales process from a suitably qualified adviser, independent legal advice for the customer, fixed interest rates and the right to move without financial penalty. SHIP represents in excess of 90% of the UK equity release market in terms of volume.

The Existing System: Lack of Public Awareness and Access to Financial Advice

One of the principle barriers to the development of financial products under the current long term care system is a substantial lack of public awareness and understanding about long-term care needs. Long term care is often perceived as an emergency purchase and something that cannot be effectively planned for in financial terms. Similarly, people do not know enough about the different financial options that might assist them in financing long term care needs. Contributing to this is the uncertainty in the current financial model and a lack of confidence that a particular product will remain fit for purpose. There are equally concerns about access to independent, high quality, holistic advice about later life planning. There is a scarcity of such information to help people understand the system when approaching retirement. As the Government’s plans for long term care funding move forward, people will need to have access to a range of assets, and an understanding of how these can be used to meet the financial contribution expected of them under a partnership funding model.

Housing Wealth

Dilnot specifically identifies that new mortgage based solutions can be developed to meet the needs of people who may decide to use some housing wealth to meet their contribution to costs under the proposed cap. Analysis from the Pensions Policy Institute estimates that £250 billion of equity could be released immediately. For many, housing equity will be the most viable financial asset on which they can depend. More than two-thirds of over 65s are homeowners without a mortgage and could utilise equity release to supplement retirement funds or pay long term care costs. It is essential to consider how property and housing wealth could contribute to general financial or retirement planning.

Equity Release

SHIP considers that equity release will be one of the methods by which an increasing number of people may choose to fund their social care. It allows people to access the money tied up in their homes without having to actually leave their homes; to help people live more conformably in their homes, for example by paying for domiciliary care or home adaptations. There have been a number of product innovations in equity release products specifically with care needs in mind, including impaired life products and the facility to release regular, amounts of equity which does not affect entitlement to state benefits. However, it is SHIP’s experience that people simply do not realise that equity release can be used to fund domiciliary or long term care. SHIP would like to see the Government adopt a clear position on equity release by acknowledging that for some people it is a viable, mainstream option for retirement or long term care planning. Information on equity release and signposting to advice should be included as a viable solution in the “major new information and advice strategy” on long term care.
Future Funding of Social Care

A partnership model as advocated by Dilnot does provide a framework within which financial products can be developed. However, SHIP would also caution that there is still need for more clarity about what care purchases will count towards an individual meeting the proposed cap on costs. For example would this cover home adaptations or other preventative measures. Equally, there needs to be far more clarity around “residential” or “hotel” costs as this will be means-tested and it will be important to ensure people do not have a false sense of security about what they need to contribute and forgo the need to seek financial advice.

16 November 2011

Written evidence from The Strategic Society Centre (SC 80)

Summary

This memorandum explores:
— The precise functioning of the “capped cost” model, put forward by the Dilnot Commission on Funding of Care and Support;
— The advantages and disadvantages of the “capped cost” model;
— The potential role of financial services products in the context of the “capped cost” model.

About the Strategic Society Centre

The Strategic Society Centre is a London-based public policy think-tank, founded in 2010. The Centre has a simple mission: to examine the big, strategic challenges facing policymakers and society. These are the problems that are the most complex for government to solve, which cut across distinct policy domains and require multiple different types of strategic intervention.

Our work is built on the application of strategic policy analysis—a distinct set of analytical techniques developed in Whitehall to provide Ministers with highly evidenced, reasoned, innovative policy recommendations and ideas. In the focus of our work and the way we do it, the Centre is modeled on Whitehall strategy units that exist within key government departments. All our work is independent, objective and free of partisan association, allowing us to engage with the broadest possible range of stakeholders and policymakers.

The Strategic Society Centre is a registered charity (No. 1144565) incorporated with limited liability in England and Wales (Company No. 7273418).

About this Memorandum

The Committee has indicated that it will consider, amongst other issues:
— The practical and policy implications of the Government’s plans for funding social care, and the recommendations made by the Dilnot Commission and the Law Commission;
— The scale and implications of existing variation in access to and charges for social care in England;
— The practical and policy implications of the Government’s commitment to promote personalisation of social care, including personal budgets and direct payments;
— The barriers faced by recipients of social care when they wish to relocate to another area, particularly with regard to the portability of assessments;
— Economic regulation of the social care system including a proportionate failure regime that can mitigate against the failure of social care providers;
— The practical and policy implications of the Government’s stated commitment to promote integration between health and social care services.

Much of the analysis presented in this Memorandum draws upon the Strategic Society Centre’s “Care Funding Futures” work programme, which was made possible by the support of Bupa, PwC, Age UK and Tunstall. The outputs of this work programme can be downloaded from the website of the Centre at: www.strategicsociety.org.uk

The “Capped Cost” Model

Introduction

The central recommendation of the Dilnot Commission on Funding of Care of Care and Support is the “capped cost” model.

It is important to underscore from the outset that the Dilnot Commission was set a specific brief, which focused on protecting families from “catastrophic costs” of care and improving the “partnership” between individuals and the state in regard of the funding of care-related costs.
As such, the Commission was tasked to produce a spending proposal: ie recommendations for how money is spent by the state on care and support for the population. The Commission was not asked to produce a funding proposal: ie recommendations for how more money could be directed into the social care system from a variety of public and private sources.

The constraints imposed on the Dilnot Commission from the outset are very significant. Like many developed countries, England confronts rising care needs in the future, associated with the ageing of the population. Projections published by the Commission show that just to maintain existing spending on care and support—in the form of disability benefits and the local authority social care system—public spending will have to increase by around £12 billion per year by 2025. As such, how to fund this growing public spending gap remains the principal public policy challenge associated with social care funding in England, but the Dilnot Commission was specifically directed not to provide recommendations on this issue.

What is the “capped cost” model and how would it work?

Since publication in July 2011, the precise detail and functioning of the “capped cost” model put forward by the Dilnot Commission has led to a great deal of misunderstanding and confusion. The key components are as follows:

1. A cap on exclusion from means-tested local authority support, with a threshold of £35,000 the recommended level;
2. An increase in the upper capital limit of the means-test for residential care to £100,000.

For individuals below the age of 40, the Commission argues the £35,000 cap should be set at zero, but should then increase by £10,000 every ten years, until a person reaches 65.

The Commission also argues that since it is reasonable to expect individuals to plan for their living costs in retirement, individuals receiving state-funded residential care should, provided they can afford to, make a contribution to the cost of their residential care proportional to these living costs. The Commission recommends that retirees should make a contribution toward living costs in residential care of between £7,000 and £10,000.

It important to clarify the precise functioning of the “cap” proposed by the Commission. Under the model, every individual would be entitled to a local authority needs-assessment, as currently provided by councils. For care in a person’s home, assessments of need would—as now—determine need proportional to any informal care provided.

If individuals have a qualifying level of assessed need, they would then be subject to a means-test. If individuals had income and wealth that placed them below the means-test threshold, they would—as now—be entitled to free personal care, or care with some limited charging applied.

If individuals had income and wealth that placed them above the means-test, they would not begin receiving support from their council. Instead, their council would use its Resource Allocation System (RAS) to determine a financial value of support that the individual would have received if they did qualify for support. The council would then “meter” this notional amount on a weekly basis until it accumulated to £35,000 (or whatever level the cap was set at). When a person’s notional support reached £35,000, they would be reassessed on a means-blind basis, and would begin receiving actual support, proportional to their assessed need.

As such, although the Commission has referred to its model as the “capped cost” model, this is perhaps a slightly misleading name, as it has led many stakeholders to believe that under the model, individuals would simply purchase care privately, and when their accumulated receipts for care totalled £35,000, they would then be entitled to free care from their local authority.

Rather, the model could be more accurately termed the “capped exclusion from means-tested support” model, as it effectively limits how much council-funded support individuals are excluded from on account of being too wealthy.

(A) The advantages and disadvantages of the “capped cost” model

The principal advantages of the “capped cost” model are:

1. Reduced “spend-down”:
   At present, many individuals in the social care system are exposed to “catastrophic” accumulated costs, on account of requiring high-level expensive care for a long-period. The “capped cost” model would reduce the prevalence of individuals spending down a “catastrophic” proportion of their total wealth, in comparison to both the current system, and similar “partnership” models of public spending on social care, such as the “King’s Fund” Partnership model. However, as explored below, in many instances, the “capped cost” model would not in fact place a limit on how much individuals spent on their care, owing to the role of “out-of-pocket” top-ups for residential care.

2. Peace of mind:

147 Commission on Funding of Care and Support (2011). Fairer Care Funding: Volume 2—Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support, London.
The “capped cost” model would provide some peace of mind to the whole population that in the event of needing care, after a certain point, the state would pick up a significant proportion of their costs.

(3) Providing the opportunity to prepare for care costs:
At present, individuals who wish to make financial preparations for the potential costs of needing care in the future are not provided with any clear framework to do so. However, a “cap” of £35,000 would give individuals the opportunity to make preparations for how such costs would be paid for, for example, through the “decumulation” of housing equity.

The principal disadvantages of the “capped cost” model are:

(1) Failure to fully cap costs:
The vast majority of private “self-funders” in residential care pay more in fees than the benchmark amount their council would pay for a place in a care home. Across England, the average weekly fees paid by councils for residential care is estimated to be around £498. Self-funders in residential care frequently pay far more than this, sometimes even up to £2,000 per week. As such, under the “capped cost” model, if someone’s “meter” began accumulating at the point they entered residential care, they could be paying, for example, £750 per week, while their meter might only increase by £500 per week. After 70 weeks, the individual would have hit the council’s £35,000 cap, even though they would have already paid £52,500 in fees. At this point of reaching the cap, they would begin receiving £500 from their council, but would continue to have to top-up their fees by £250 per week. As such, the majority of self-funders in residential care for an extended period would not in fact have their costs capped by their council. Instead, the “cap” would effectively function as a generous, delayed “co-payment”.

(2) Limited peace of mind:
Given the fact that the “capped cost” model would not fully cap costs, there is inevitably some uncertainty regarding the “peace of mind dividend” that would accrue to the population owing to the “capped cost” model. It would remain to be seen whether the public would ignore or overlook the fact that those paying more than the benchmark fees paid for by councils in residential would continue having to top-up their fees. The peace of mind provided to the population may also be undermined in practice, by the fact that the “cap” would have to be uprated on an annual basis—for example, in line with consumer price inflation—potentially leaving some individuals feeling that they are “chasing a moving target”.

(3) Pre-funded insurance:
No country in the world has a properly functioning pre-funded insurance market for social care. It has been suggested that the “capped cost” model would encourage such a market. However, because the only realistic effect would be to reduce the price of premiums, and because of technical issues involving the interaction of private insurance and a “cap” set by the government—explored below—it is highly unlikely that the “capped cost” model would bring any new significant funding into the social care system via private pre-funded insurance or disability-linked annuities.

(4) Implementation issues:
No country in the world operates a “limited liability” model of the type proposed by the Dilnot Commission. As such, the “capped cost” model poses a number of uncertainties and questions related to implementation. In brief, these include:

(a) RAS: The “capped cost” model relies on the effective operation of council Resource Allocation Systems, which allocate a financial value to council support provided to an individual, regardless of what form they take that support in (cash or services). However, RAS systems are still a relatively new introduction to the social care system in England and represent a “work in progress”. The government would need to be clear that all councils were operating RASs satisfactorily before implementing the “capped cost” model.

(b) Social workers: There would be some uncertainties regarding how social workers respond to allocating “notional” support to individuals under the “capped cost” model. For example, would some be overgenerous in their notional allocations, ultimately increasing the costs of the system?

(c) Gaming by households: it may be that the “capped cost” model would be susceptible to, and would incentivise, gaming by households allocated “notional” support; for example, family carers deliberately understating their capacity to provide informal care, in order to increase the “notional” amount of support the person they care for is allocated. Such incentives exist in the current system, but would arguably be amplified under the “capped cost” model, in that fraud and gaming may be more likely in relation to “notional” amounts of public spending, and more households would be subject to needs-assessments by their local authority, but then be told that they are “too wealthy” to be entitled to support.

(d) **Budget management by councils**: local authorities would be responsible for implementing the £35,000 cap in the context of autonomous budgeting decisions on council spending and levels of support to individuals. As such, faced with a duty to implement the cap, it would remain to be seen whether councils would seek to manage their budgets in a way that would undermine the model; for example, effectively increase the needs-thresholds to qualify for council support as a way of targeting resources as they chose.

In sum, there is a compelling case for the government to pilot the “capped cost” model before implementing it across the country.

This section has briefly outlined some key advantages and disadvantages of the “capped cost” model. The “capped cost” model would cost £2.2 billion in 2015 rising to £3.6 billion in 2025 (2010 prices). Ultimately, the government must decide whether this represents a good use of this additional public spending on social care, and this is a political decision regarding priorities.

**The “Capped Cost” Model and Financial Services Products**

The Committee has indicated a particular interest in how the “capped cost” model would interact with financial services products. This section therefore outlines five different types of financial products, and considers their interaction with the “capped cost” model.

1. **General savings and care-specific savings products**

   It has been suggested that individuals could undertake liquid saving toward their individual liability under the “capped cost” model. However, there is no evidence to suggest that the “capped cost” model would encourage individuals to engage in more general saving. Surveys of household savings priorities have not previously revealed savings decisions to be based on the risk of needing care, as opposed to other expenditure requirements, such as buying a car, a house, a holiday, etc.

   As an alternative to general saving, it has been suggested that individuals could save into “Care ISAs”, which would comprise additional tax-incentivised savings target for saving up to the value of an individual’s liability—£35,000—on top of existing individual ISA allowances, with the use of the funds in a Care ISA conditional upon experiencing care needs. However, such a model must be put in the context of the low level of liquid saving among households; for example, around 60% of employees in the UK have less than £5,000 in liquid saving.\(^{149}\) In addition, individuals of working age would be better advised to place their spare income in a pension—which benefits from superior tax incentives than ISAs—rather than a “Care ISA”, and which can be used to provide a flexible income in retirement. Although individuals in retirement could contribute to a “Care ISA”, low levels of income among retirees and the limited scope for liquid saving—and potential other income needs, such as home adaptations—suggest that take up of Care ISAs across the population would be very limited.

   As such, in the opinion of the author, there is no compelling reason to think that the “capped cost” model would see an increase in general savings or the use of care-specific savings products.

2. **Equity release**

   Equity release products enable individuals in retirement to access part of the value of their home, effectively in the form of a “reverse mortgage”. For some years now, policymakers concerned with older people’s income needs have identified equity release products as a potential source of income for older people, particularly in the context of historically high rates of home-ownership among the “baby-boomer” cohort, and the inflation in UK house prices experienced over the last decade.

   The potential use of equity release has also been identified as a source of income for older people experiencing care needs. The Committee will wish to consult organisations that have done work on equity release products and their potential use in funding care, such as SHIP and the Joseph Rowntree Foundation. However, a number of general points deserve to be made:

   (a) **Demand-barriers**:

   It is generally acknowledged that equity release products confront demand-barriers that have ultimately limited the take-up of products. In particular, some households are reluctant to take on a mortgage in old age, having spent their working life making repayments so as to be free of mortgage debt. In addition, the nature of equity release products means that they may inevitably appear poor value to some customers, because factors—such as interest costs—must be taken account of in determining how much individuals receive. In the context of social care, it is not clear that the increased income needs owing to care needs results in a commensurate reduction in these demand barriers. As such, there has never been wide-ranging use of equity release products to fund care costs.

   (b) **Absence of risk-pooling**:

\(^{149}\) Forthcoming research from the Strategic Society Centre.
It is important to underline that equity release products are not risk-pooling products, and as such, should not be treated as equivalent in their “welfare gain” to individuals as pre-funded insurance or annuity-based products. Equity release offers individuals another mechanism to spend down their wealth, and any welfare gain is limited to the reduction in unmet need owing to greater consumption of formal care on account of the extra “liquidity” of assets provided by equity release.

(c) Equity release and the “capped cost” model:

The Dilnot Commission on Funding Care and Support has suggested that individuals could use equity release products to fund their care costs up to the “cap”, and commentators have suggested that take up of equity release may increase as individuals would know that there would be a cap on their care costs, and would not engage in “precautionary conservation” of their housing equity, because there would be a limit in how much they would have to pay. This represents a reasonable observation, and the “capped cost” model may result in a positive demand effect in relation to equity release, albeit against wider demand-side barriers described above. However, as explored in the previous section, some individuals may become aware that if they enter residential care, they may continue to have to pay top-up fees even upon reaching the cap—having already spent more than the notional value of the “cap”—and as such, may be resistant to spending down their housing wealth on this basis. In addition, it is worth noting that the Dilnot Commission recommended that all councils should be given a statutory duty to offer deferred payment schemes, which effectively function as council-run equity release schemes. This apparent contradiction in policy direction may need to be resolved before the government would make concerted effort to boost the use of equity release in relation to social care costs.

(3) Immediate needs annuities (INAs)

INAs are a type of insurance product that individuals purchase at the point of entering residential care. In return for a significant up-front, lump-sum payment, the annuity will pay out a regular income until a person dies, covering all (or most of) their care fees. As such, in return for a lump-sum premium, individuals purchasing INAs obtain protection against longevity-risk, ie the possibility that they will survive for a very long-time in residential care, and therefore spend down all or most of their wealth. INAs are therefore a form of “asset protection”. Several comments can be made:

(a) Suitability:

Of the 290,000 older people in residential care in England, 120,000 are self-funders.150 Within this group, around 38% (45,000) have sufficient wealth such that it would be in their “actuarial interest” to purchase an INA.151 As such, even in the context of residential care users, INAs are a relatively niche product.

(b) Take-up:

At present, the INA market is estimated to be around 7,000 policies in force, ie around 15% of the potential market. This take-up level represents various supply and demand-side barriers. Some of these could be addressed through policy measures, for example. there is arguably a cost-benefit case for all self-funders entering residential care to be given free independent financial advice, in order to reduce the number of self-funders who spend down their wealth and become reliant on council funding. However, various other demand-side barriers would remain, which would likely always limit take-up of INAs, such as consumer aversion to buying annuities.

(c) Risk-pooling:

It is worth underscoring that as a form of risk-pooling, the “welfare gain” provided by INAs is less than that provided by forms of pre-funded risk pooling, ie taxation and pre-funded insurance. Purchasers of INAs are limited to those who are unfortunate to have experienced significant care needs, and only provide protection against longevity-risk. In particular, they do not of themselves bring “new” money into the care system, but rather, help individuals with existing care needs organise their finances better.

(d) INAs and the “capped cost” model:

Under the “capped cost” model, more individuals would be able to afford INAs, and it would be reasonable to expect the market to grow. This is because at the point of entering residential care, individuals would know that at a defined point in the future, they would begin receiving a fixed amount, such as £500 per week, from their council, having reached the “cap”. As such, at this point in time, the weekly payout from an INA could drop by an equivalent amount, thereby reducing the cost of the up-front premium.

150 Commission on Funding of Care and Support (2010). Call for Evidence, Department of Health, London
(4) Pre-funded insurance

No country in the world has a properly functioning market in long-term care insurance. The international leader, France, has a take-up of around 15%, but premiums are typically low, and the proportion of care costs fundable through payouts is similarly low. In the USA, take-up in some states has achieved rates of 10%. However, this has been achieved through expensive, and frequently regressive, incentive schemes. More widely, multiple demand and supply-side barriers confront the market in pre-funded long-term care insurance, which are too numerous to detail here, but are reviewed in publications from the Strategic Society Centre, and have been extensively explored in academic research.

In Volume 2 of its final reports, the Dilnot Commission indicates that that it does not believe that the “capped cost” model would likely lead to a significant increase in the use of pre-funded care insurance (no providers currently offer such products, so the take-up rate is effectively zero).

Nevertheless, in the wake of the Commission, various stakeholders have suggested that the “capped cost” model would result in greater usage of pre-funded care insurance. It is suggested that individuals could insure themselves against their £35,000 liability, not least because the Exchequer would effectively be shouldering the key care related risks posing insurmountable “uncertainty-barriers” to private sector insurers. In addition, it has been suggested that a “cheaper” version of the “capped cost” model could be implemented, with a cap set at £50,000 or £100,000, with individuals insuring against the remaining liability.

The Centre would therefore encourage the Health Select Committee to give particular consideration as to the likely take-up of pre-funded care insurance following the implementation of the “capped cost” model.

Any increase in take-up of pre-funded care insurance would, of itself, be a good thing, as this would represent “new money” directed into the social care system, from individuals who would go on to experience care needs and individuals who do not.

However, in addition to wider problems with the use of pre-funded long-term care insurance in funding care, there are various factors to suggest that take-up of pre-funded long-term care insurance would not in fact increase as a result of the “capped cost” model.

Multiple comments can be made:

(a) Insurability of the £35,000 liability:

Insurers pricing a pre-funded long-term care insurance policy can only do so on the basis of data that can be used to project trends in disability and longevity. On this basis, insurers can make a judgement as to how likely it is a policyholder will make a claim on a policy, and how long their claim will last for.

However, under the “capped cost” model, a person’s £35,000 liability—literally, when a person reaches the cap—will be determined by their disability and longevity, in addition to, local authority needs assessments of the availability of informal care, and council decisions as to the levels of support they would provide to individuals with different types of need.

As such, it would be impossible for insurers to predict when individuals will reach the “£35,000” cap under the “capped cost” model, and strictly speaking, an individual’s liability would be uninsurable. This would have significant implications for the design of products, and would rule out a product that paid a regular income until an individual reached the £35,000 cap. Instead, pre-funded products under the “capped cost” model would likely function in a similar way to critical illness insurance, paying out a lump-sum upon a person reaching a defined level of disability, and it then being up to the household to spend down this money until they reached the threshold. However, this would yield some anomalous outcomes. For example, a person might make a successful claim on a pre-funded care insurance policy, but owing to the availability of informal care in the household, not actually have any “assessable needs” in the eyes of their local authority, with the result that their “meter” would not be accumulating.

(b) Take-up:

Any discussion of pre-funded care insurance needs to be rooted in a sound projection of likely take-up, reflecting demand-side barriers, affordability, etc. As described above, it would be illogical for individuals to purchase pre-funded care insurance when still in employment, when their risk of needing care is low, and the financial incentives to put money into a pension are higher. As such, pre-funded care insurance in England would likely be a “retirement” product, rather than a “working-age” product.

What would take-up under the capped cost model look like? It can be assumed that the premium for a pre-funded care insurance product under the “capped cost” model would be £10,000 in the context of a £35,000 cap, and nobody would spend more than one-third of their liquid saving and wealth on insuring themselves, ie nobody insures when it is not in their actuarial interest to do so. In 2012, around 716,800 people turn will 65. Around 25% of 65–74 age group has £60,000 in household financial wealth. So, it can be surmised that one quarter of the

716,800 individuals retiring in 2012, would have sufficient liquid wealth such that they could consider buying prefunded long-term care insurance for £10,000 for themselves and their partner. This amounts to a potential ‘target market’ of around 179,200 people. If an optimistic assumption is made that the take-up rate among the target market is 25%, this amounts to around 44,800 individuals per year, or 6.25% of new retirees, under the “capped cost” model. As such, with a cap of £53,000, an optimistic projection would eventually see 6.25% of all retirees purchasing long-term care insurance. If the cap were set at £50,000 or £100,000, premiums would obviously be higher, thereby reducing affordability and take-up. However, it is worth noting that even at a take-up rate of 6.25%, it is not conclusively clear that this would represent a viable market for insurers.

(c) Timing:
It is worth highlighting the time-delay between purchase of care insurance, payout, and implications for the long-term care funding system. If pre-funded long-term care insurance products were reintroduced by 2015, and immediately saw 6.25% of new retirees purchasing policy, and if it is assumed that the average of claim is 75, then it would be 2025 by the time that pre-funded care insurance would actually begin directing money into the social care system. At this point, the demographic cost-pressures on the existing social care system would already have reached their zenith.

(5) Disability-linked annuities

The final financial product worth reviewing is disability-linked annuities (DLAs). These are a type of annuity product that could be purchased by retirees with defined-contribution pensions (about half the labour force). DLAs would pay out a higher income when someone experienced care needs, in return for paying a lower pension income before someone experienced care needs. If DLAs were purchased in the context of the “capped cost” model, the “disability-uplift” they paid out could be limited to £35,000.

However, analysis suggests that any potential market for DLAs is likely to be extremely limited for a number of reasons:

(a) Affordability:
Most defined-contribution pension annuitants retire with relatively small pension pots of around £25,000–£40,000. If the embedded premium of a DLA for a £35,000 “disability-uplift” was £10,000, this would see individuals effectively having to spend a large proportion of their defined-contribution pension pot on obtaining protection against care costs, in the context of what would otherwise only be a very low pension income anyway. As such, the number of defined-contribution pension annuitants who could realistically afford a DLA is low.

(b) Demand-barriers:
There is widespread recognition among pension policymakers and the insurance industry that individuals purchasing annuities with their defined-contribution pension pots frequently make poor choices. In particular, many men retiring from the labour force obtain “single-life” rather than “dual-life” annuities, with the result that their partners, confront poverty after they die. In addition, many annuitants do not obtain protection against inflation, i.e. an annuity that increases the value of the income it pays over time. As such, the longer they live, the real value of their pension income is eroded by inflation. The root cause of these problems is that defined contribution pension annuitants usually opt for the highest immediate income payable. Since a DLA would also require a lower immediate income payable from an annuity, it is therefore likely that few individuals would purchase such products voluntarily, and indeed, from a policy perspective, there is a compelling argument that policy should be directing individuals to purchase inflation-linked, dual-life annuities before obtaining disability protection.

In conclusion, it is the opinion of the author that the only type of financial services product that would experience any significant growth following the implementation of the “capped cost” model is Immediate Needs Annuities.

Conclusion

This memorandum has explored the advantages and disadvantages of the “capped cost” model put forward by the Dilnot Commission on Funding of Care and Support. It has also explored the potential for financial services products to operate in the context of the “capped cost” model.

No model of how the state spends public money on supporting individuals with care and support needs is perfect. The Dilnot Commission’s “capped cost” model represents one suggested configuration for the shape of state support. However, many others are possible, reflecting variations in the different levers available to policymakers, notably: the lower and upper capital limits used in local authority means-tests; the proportion of costs funded by the state to individuals with different levels of wealth; and, how the level of support varies at different points in the care journey, for example, reflecting accumulated need (i.e. a cap).
Different potential configurations reflect complex trade-offs and political choices. However, at this stage of policy development, and in the context of growing demand for care resulting from population ageing with its implications for the fiscal sustainability of the current system in England, the key task for policymakers is arguably to decide how much will be spent by the state on care and support now and in the future, and how any new, extra, spending commitments will be met. This is the crucial question: the precise shape and configuration of state support, whether or not it closely resembles the “capped cost” model put forward by the Dilnot Commission, can be decided later.

Further Reading


Supplementary written evidence by the Law Commission (SC 81)

LAW COMMISSION REPORT ON ADULT SOCIAL CARE

First, I want to thank you for the interesting and stimulating session with the Committee yesterday morning.

We have reflected on Members’ concerns about the relationship between our report and the Health and Social Care Bill and our report and the changing climate of health and social care provision. It may assist to set out the extent to which our final recommendations were amended to take into account those factors. In particular:

— Our general duty to cooperate was constructed to ensure that social services membership on Health and Wellbeing boards was one of the ways that this duty could be discharged.

— We extended our list of bodies to which the duty to consult applied to include likely members of Health and Wellbeing Boards.

— We significantly altered our recommendations in relation to the important duty in Mental Health Act 1983, section 117. For example, we recommended that the joint duty in section 117 should be divided between health and social care and that section 117 should be recast from a free-standing duty to a gateway provision, in order to take into account the amendments proposed to section 117 in the Health and Social Care Bill.

— We reviewed the guidance on NHS Continuing Healthcare and argued that it needed to be revised to take into account the Health and Social Care Bill and our recommendations in relation to section 117 of the Mental Health Act 1983.

— Several of our final recommendations will impact on the NHS, such as the duties to cooperate, the health and social care divide, and statutory safeguarding boards. The final report makes reference to “NHS bodies” or “NHS authorities” in relation to these provisions in order to take into account the proposed introduction of commissioning consortia and NHS Commissioning Boards.

In other words, we are confident that all our recommendations in these areas will apply under the proposed new NHS regime and take into account the changing landscape of health and social care provision.

However, I do accept that during the Parliamentary passage of the bill important changes have been, and may still be made, and the process of Parliamentary scrutiny may bring out other issues. As a result I think that we should, as Members suggested, take the opportunity to look again at our report when the bill is enacted. We can then consider whether there is any further need to refine or amend our proposals. When the bill is enacted, therefore, we will review the relationship between the Act and our proposals, and publish the results of our considerations.

Our review will not affect the timetable that I outlined that we would like to see for any social care reform bill, namely, for its introduction in the second parliamentary session, but will enable your Committee and others to be re-assured as to the robust and future proofed nature of our proposals.

I hope the content of this letter will help the Committee in your enquiry.

23 November 2011
Written evidence from the National Housing Federation (SC 82)

The National Housing Federation is the voice for affordable housing in England. Our members provide two and a half million homes for more than five million people. Every year they invest in a diverse range of neighbourhood projects that help create strong, vibrant communities.

Approximately half of our members deliver housing, care and support services to some of the most vulnerable people in society, including people with learning disabilities, people with mental health problems, older people with care or support needs, homeless people, and women fleeing domestic violence. The wide range of services provided includes: help in setting up and looking after a home or tenancy, support with developing independent living skills, help to develop social networks, manage money and to stay healthy and access health services, and assistance to arrange repairs and home improvements as well as social care.

1.0 Summary of Recommendations

— The Health and Social Care Bill and subsequent guidance should join-up housing, health and care. To deliver improved outcomes there needs to be clear and practical links with housing through Health and Wellbeing Boards, local strategies, needs assessments and commissioning.
— We support the implementation of the Dilnot Commission’s recommendations as a clear way forward on the funding of future care needs and integrating health, care and housing.
— Widespread cuts to housing-related support by many local authorities will make it harder to deliver the Government’s vision for social care because they strip away a vital layer of preventative support. There needs to be a robust accountability framework for local spending on preventative support services.
— Local leadership and innovation is required to pool budgets and incentivise a focus on prevention in commissioning of services.
— Local authorities should actively manage their local market of care and support. This should entail ensuring a diversity of housing, care and support options to meet local needs and building in sufficient preventative services to reduce demand on acute services.

2.0 The Role and Value of Housing Associations to Social Care

Housing associations provide a wide range of services that deliver social care outcomes. Strong partnerships between housing providers and local health and social care commissioners bring together the necessary expertise and capital and revenue funding to ensure viable and appropriate services. This submission highlights a number of effective examples of this. However, there is a bigger opportunity to include housing as an integral part of strategic planning and commissioning of care services in the future.

A care system that delivers better outcomes for individuals and communities, personalised and preventative services alongside efficiency savings necessitates integration with housing and support.

The Health and Social Care Bill, and subsequent guidance, is a significant opportunity to join up housing, health and care. To achieve this at a local level we need to see housing representation and voice on Health and Wellbeing Boards and ensure that housing needs are integrated into Joint Strategic Needs Assessments.

The Government’s vision for social care, set out in Capable Communities and Active Citizens emphasises the importance of individuals having control over their own care, and the need for a diverse range of providers to deliver personalised care and support. Housing is recognised in the vision as an important wider support service that enables the care system to build community capacity and deliver preventative services that intervene early.

Where people live is one of the key determinants of health. Good housing is in itself a preventative investment. Settled housing improves health and reduces the incidence of respiratory and other diseases.153 For people with a mental illness, for example, having a settled and secure place to live is critical to recovery.

Appropriate housing with care and support can also enable people to remain independent and receive health, social care and support services in their home rather than have to move to more institutional settings, including hospital. Delivery of preventative services to people as they age, or their needs change, can reduce or slow the need for more intensive and expensive support services and interventions. Housing associations can offer flexible levels of support in a community setting, and can provide better outcomes at lower costs for people and their carers than traditional high cost nursing and residential care.

Housing associations are major developers and managers of both mainstream and specialist housing specifically designed and built to facilitate and deliver care and support services. Most people aim to, and do, remain in their own homes throughout their lives. If these homes are adapted as people’s physical needs change or designed with flexibility built in from the outset, this facilitates the delivery of social and domiciliary care and support services to people within their own homes assisting them retain their independence.

For some people with care needs, specialist housing is more appropriate, as it is designed to facilitate and provide the support and care services they require. The spectrum of services range from low level support to more intensive care and support, for example:

- Sheltered housing, extra care housing, and care and support services for older people to help them continue to live in their own home rather than move into residential care.
- Supported housing and flexible support to help people with mental health needs stabilise their lives, recover or maintain a tenancy and live more independently.
- Services for homeless people with complex and multiple needs. This includes drug and alcohol misuse and mental ill health, where clients can fall between the gaps between traditional services.

3.0 Evidence of the Value of Housing to Health and Care

As well as achieving health objectives, housing-related support is cost-effective and offer good value for money. Through the wide range of care and support services that housing associations provide, real cost benefits are delivered across a range of service areas.

The Department of Health’s Care Services Efficiency Delivery team’s research compared the outcomes and costs of a number of housing-related support projects with the likely alternative services for clients if those projects were not available. This demonstrated that investment in a range of preventative support and housing based services leads to better outcomes for the users of the service, their families and brings savings to the taxpayer, through, for example, the avoidance of hospital admissions and reduced numbers of children being taken into care. They also enabled people to exercise greater independence, choice and control over their lives.154

Between 2003 and 2009, housing-related support services were funded through the Supporting People programme. The Cap Gemini study of the benefits of the Supporting People services estimated that a £1.6 billion annual investment in housing-related support services generated annual cost savings of £3.41 billion to the public purse, including to health and social care.155

Frontier Economics’ analysis of capital investment in specialist housing with care and support concluded that investment by the Homes and Communities Agency in specialist housing for nine client groups delivers an annual net benefit to the exchequer of £639 million; including £219 million a year from older people’s housing, £199 million a year from specialist housing for adults with learning disabilities and £187 million a year from specialist housing for people with mental health problems.156 The Department of Health highlighted this research to local authorities in its December 2010 Local Authority Social Services Letter regarding capital grant funding.157

The Marmot Review of health inequalities identified housing conditions as one of the key social determinants of health inequality, alongside child development, education, employment, and standard of living. The Review also recognised the need for developing sustainable places and communities, something that many housing associations are engaged in.158

4.0 Challenges and Opportunities in Integrating Housing and Care

4.1 Joining-up commissioning

Many local areas are progressing partnerships with housing associations to improve services, achieve better outcomes and reduce costs. However a number of barriers exist to fulfilling this potential. One of the key challenges is the need to join-up strategic and local commissioning between housing, social care and health. Research published by the National Housing Federation has shown that only 20 out of 152 Primary Care Trusts scored highly (level three or above out of four) on the previous collaborative working competency.159

The financial benefits of housing-related care and support services often extend the beyond local authority to other areas of public spending, like health and wellbeing and community safety. Gaining local support for such schemes means local partners need to align priorities and funding streams across a number of different organisations and service areas. To achieve this there needs to be ways of valuing and prioritising broad health and wellbeing outcomes across health, care and housing.

The Government supports Community Budgeting as a route to pooling local funding to improve services and focus more on outcomes rather than the limited scope of existing services or budgets. Initial pilots have

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158 Ibid
159 Health Mandate, Housing for Health: Worlds Aligned, National Housing Federation, 2010.
focused on intensive support for families with multiple problems and opportunities should be sought to extend this approach to delivering health and wellbeing outcomes in community settings.

The changes in commissioning that will be delivered through the implementation of the Health and Social Care Bill create opportunities to build in joint working and partnership between health, social care and housing so that the cost savings identified above can be realised and that people receive the services that they choose, in homes that they want to live in. While the Bill creates a framework and environment that is more conducive to the integration of local services it does not guarantee it. Local leadership, consultation and involvement of housing providers will be critical for the new bodies and forums to connect housing, health and care together in ways that will deliver better outcomes. Links with housing could be made at all stages of service planning, commissioning and delivery.

Recommendations

Housing needs voice and representation through the Health and Wellbeing Boards to help local integration of services beyond health and care.

Joint Strategic Needs Assessments of health and care needs (JSNA) should be linked to an up-to-date housing needs assessment. As JSNAs are developed they should draw on the knowledge and intelligence held by housing associations about the health and care needs of vulnerable groups.

Clinical commissioning groups (CCGs) and local authorities should align their strategies and commissioning functions to ensure they are making the best use of their shared resources and enabling more people to receive the care they need outside hospital settings.

To ensure the Bill’s commitments to tackling health inequalities are actionable and meaningful local strategies should be informed by data from housing and support providers to focus attention on marginalised groups and communities who experience particularly poor health outcomes. This should include data on the needs of those with experience of homelessness or vulnerable people in poor or unstable housing. These groups will have severe needs but may be numerically small and not clearly defined unless existing assessments of housing and health disadvantage are brought together.

Local authorities should test a variety of approaches to pool and align budgets to deliver more joined-up housing, care and support. This could include exploring the use of a community budget approach to bring together capital and revenue funding for supported housing.

To improve outcomes and make more effective use of resources, health commissioners should work with housing associations to plan how housing fits into integrated care pathways. Nationally, the NHS Commissioning Board should champion and lead and help co-ordinate this.

4.2 Investment in preventative services

There is a growing evidence base that housing-related interventions can prevent or delay people entering the social care system and produce better outcomes for people at a lower overall cost. As the Dilnot Commission Report recognises, integrating housing, health and care is essential to delivering preventative services that deliver better outcomes.

However, the vast majority of local authorities in the country set their eligibility criteria for care at “substantial” and above. Between 2003 and 2009 the funding for a number of preventative services such as support for older people living in sheltered housing or independent living skills for people with a learning disability or mental ill health came from through Supporting People funding. This programme existed alongside, rather than integrated into, local authority responsibilities for adult social care. While housing-related support also provides assistance to those outside the care system but in need of support, these services picked up some of the lower level needs within the low and moderate Fair Access to Care Services (FACS) criteria.

The Spending Review 2010 maintained national investment in Supporting People services in cash terms over the next four years. However, as part of the Spending Review’s commitment to give local authorities more freedom funding for these services was rolled into the Formula Grant. There is no statutory duty to support many of the groups assisted by Supporting People services and no clear mechanism for service users, citizens and providers to track the funding that local authorities have allocated and spent on those services.

A survey of Federation members last year found that about three-quarters of respondents expected cuts of over 12% over the next four years. Over 40% of respondents were expecting cuts of over 21%. We have since seen local authorities pass budgets with large cuts to housing-related support services for this financial year.

During this time of such significant cuts in public spending and wide scale reform to public services, there is a need an opportunity to reassert the importance of preventative services in meeting people’s needs. Without this vital layer of preventative housing-related support it will be impossible to deliver the Government’s social care vision or improve outcomes for a number of excluded and marginalised client groups.
Recommendations

To achieve a focus on prevention the future care system needs to extend its commitment to integrate services beyond health and care to housing and community support. National and local commissioners need to be able to value and prioritise services that prevent the need for acute services and save costs across the whole system.

Central government should support and champion a framework for local transparency and accountability for the expenditure on housing-related support as lifeline services for some of the most vulnerable in society.

Local authorities should prioritise strategically important housing related support services and avoid cutting non-statutory support services disproportionately.

Local authorities should also be supported to provide comparable information on expenditure, provision and outcomes of services for vulnerable people as part of the Government’s broader commitment to openness and transparency in public services.

4.3 Combining capital and revenue funding

Some housing schemes will have both social care and health investment to deliver services and capital funding to develop or remodel accommodation to deliver those services from. In developing a new specialist housing scheme a housing association may be able to obtain a proportion of the capital costs from public grant, however it will also borrow money and often draw on its own resources as well. The Spending Review 2010 brought in a new investment framework for the building of affordable housing, including supported and specialist homes. The overall capital grant was cut by 63% and new homes will be funded through a new Affordable Rent product. The Homes and Communities Agency retain a strong corporate commitment to deliver a proportion of supported and specialist homes through the reduced funding pot. However, the scale of cut to capital investment requires housing associations and social care commissioners to look to alternative sources of capital investment to meet the scale and diversity of local needs.

To fund the management of the scheme and deliver housing services, the association receives rent and service charges from residents. The care and support services are commissioned by and contracted and funded by local authority social care teams, sometimes through prevention strategies or Supporting People teams and/or health.

A number of schemes provide a mix of housing tenures. This is often a vital way of meeting the range of local needs but it also creates a complex web of funding and relationships that housing associations and commissioners have to manage and deliver through. This can involve partnerships with different tiers of local government, and bringing together capital funding, discounted local authority land and land purchased from the NHS estate.

Housing is integral to delivering genuinely personalised services. An individual’s housing circumstances can make a huge difference to their ability to exercise choice and control over their care and support. However, with greater use of individual purchasing, there is a risk that some accommodation-based models of care and support may become unviable because of the degree of core costs of housing-based projects. This would be counter-productive to true personalisation and reduce the level of choice and range of services available to clients.

However, several pilots have shown the different approaches housing associations and commissioners can take personalise services in a way that combines meaningful choice and control for service users with a degree of block-contracting maintaining overall scheme viability. Different clients want different levels and types of choice so a diversity of approaches is needed to achieve personalisation.

Housing associations can be skilled local partners for local social care and health bodies. Housing associations bring the expertise in housing design and development and are able to lever in private finance in the form of loans to co-fund schemes. However the association takes a risk that the specialist building will continue to be used as a resource for the local community to meet the identified need. This highlights the need for local commissioners to fully understand the valuable role that housing play in delivering their social care outcomes.

Recommendations

Nationally the NHS Commissioning Board should support trusts, social care departments and providers to explore ways to link capital and revenue funding to deliver the specialist and supported housing we need.

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160 For a case study of this, see, National Housing Federation (2011) Breaking the Mould: Re-visioning older people’s housing, pp21–22
www.housing.org.uk/publications/find_a_publication/care_and_support/breaking_the_mould_re_vision.aspx


The Government should support the development of a wide range of personalised options and help share learning between local authorities and providers on models of services, contracting and brokerage that work for service users, commissioners and help sustain a variety of accommodation-based projects.

4.4 The Dilnot Report and use of housing equity

We support proposals made in the Dilnot report to explore how equity release models may be developed and diversified to meet a range of needs.

Research by One Housing Group has shown that equity release is currently used to fund care and support for older people in only 1% of cases, compared to 70% of cases where it is used for home improvements or adaptations. Surveys and focus groups with older people have demonstrated an interest in using equity to fund care and support in old age, but also pointed to the need for products need to be simple to understand, cheap to administer, and flexible enough to adapt as care and support services develop to meet a range of different personal circumstances.\(^{163}\)

Recommendation

More detailed examination should be given to the potential of housing equity to fund care and support services in a planned way so that people have choice and control over both their services and where they live.

4.5 Use of assets and the NHS estate

With such significant pressure on public spending and widespread cuts to preventative housing-related support services, commissioners and providers need to look to a variety of different ways of delivering new services.

There are already examples of social services and local authorities providing discounted or free land in order to ensure the viability of new accommodation schemes that deliver local priorities. Flexibilities available to foundation trusts provide opportunities for real innovation and creativity in the use of existing estate. Housing associations are well placed to offer the NHS new ways of using the NHS estate creatively to deliver the facilities that local residents require whilst improving health outcomes.\(^{164}\)

Recommendation

NHS bodies should explore opportunities to use the existing NHS estate in different ways to deliver better health outcomes. This could include for example, partnerships with housing associations to ensure Trusts have accommodation available to support speedy discharge and step-down services.

5.0 Partnership with Health and Social Care: The Housing Association Offer

The rest of our submission highlights a number of examples of the different ways in which partnerships with housing associations can deliver better social care outcomes for a variety of client groups.

5.1 Prevention and Early Intervention

Housing associations and support providers deliver preventative and early intervention services that support or prevent needs becoming more severe. By promoting independence, improving people’s health and reducing the need for more acute care services, housing associations deliver cost-effective support.

Housing associations also have a good track record of delivering services that are designed to promote health and wellbeing, to prevent falls, accidents and promote independence through the provision of technology, equipment or adaptations. PCTs have shown the greatest appetite to commission services that are explicitly designed to prevent hospital admission. As the NHS develops a more mutual relationship with patients and supports them to make good choices about their own health, such services have a clear role to play. In the example below from St Helens the PCT has funded early intervention to prevent over-representation on acute mental health services of people who experience disadvantage.

Helena Partnership—Community Wellbeing

A Community Health and Wellbeing post, funded by Halton and St Helens PCT, provides preventative services, advice and information to deliver public health improvements in areas of greatest deprivation; it also supports implementation of the local mental health promotion strategy. Working in partnership with the public health delivery team and leads for adult mental health promotion, suicide prevention and child and adolescent mental health promotion, the role has shown improvements in self-reported mental health and reduced likelihood of stair casing into acute services.

\(^{163}\) One Housing Group (2009): Aspiration Age—Delivering capital solutions to promote greater choice and independence for older people

www.onehousinggroup.co.uk/papyrus/files/documentmanager/Aspiration%20Age_full%20report.pdf

\(^{164}\) NHS Confederation and National Housing Federation (Dec 2011)—Housing and Mental Health

www.nhsconfed.org/Publications/Documents/Housing_MH_021211.pdf
5.2 Low level support that builds recovery and inclusion

Housing associations provide services to the wider community as well to residents of their own schemes. This includes providing a resource for the community or outreach services to people in their own homes. Darwin Court a development by Peabody Housing Trust is a social housing scheme for people over 50 and provides a range of support services to residents. It also has a resource centre on the ground floor including consultation rooms, an IT suite, restaurant and swimming pool, all of which have created a significant community amenity and contribution to health and wellbeing in the area.

Each year housing associations invest in a diverse range of neighbourhood projects that help create strong, vibrant communities. In our neighbourhood audit, the Federation found that housing associations delivered 6,800 diverse neighbourhood services and facilities such as community centres and sports facilities and other initiatives which benefited around 5.5 million people and contributed to the economic, environmental and social stability of local neighbourhoods.165

5.3 Housing and services that maintain independence

There is a wide spectrum of housing provision for older people ranging from sheltered to extra care housing.

Sheltered housing may provide an onsite or visiting warden and are usually equipped with telecare systems to provide security for residents and enable them to call for assistance. Whilst care is not provided on site as part of the service, residents may receive domiciliary care in their own homes. Extra care schemes will have a range of facilities over and above those of sheltered housing and have on-site care staff providing services to residents with a range of needs from low to high care including dementia. Extra Care is now being used for intermediate care and rehabilitation as well as longer term housing and offers a route to more integrated delivery of housing, health and social care needs.

The ILC’s report on extra care reported substantial reductions in additional social care needs amongst extra care residents, as well as a lower uptake of hospital inpatient beds and a lower number of falls.166

Irwell Valley Housing Association’s Shore Green Dementia Service167

Based in the Shore Green extra care scheme in Manchester within 10 flats, the service offers a specialist care service for older people with dementia and other memory loss conditions. The scheme has a communal lounge, kitchen and garden and enables residents to continue a level of independent living in an environment where support is available when it is required and which has been designed to support people with dementia for example: gas monitors, door sensors, and colour coding of areas. The Care Services Efficiency Delivery analysis concluded that the service at Shore Green offered good value for money: better outcomes were being achieved at a marginal extra cost. Additionally, this cost comparison is before any savings related to A&E, hospital, ambulance or police are taken into account. The evaluation concluded that the Shore Green model would provide people with dementia with a better quality of support and cost the wider health and social care system less than traditional nursing and residential support options.

The Federation’s Breaking the Mould project reflects the diversity and changing trends in the social care market for older people. It shows how housing associations are broadening their housing offer for older people, including:

- Developing home ownership options which take into account the high levels of owner occupation and housing equity owned by older people.
- Broadening out services and facilities to the wider community, including services for self funders and providing commissioned services to the wider community, including working with the NHS to accelerate discharge from hospitals, better integrating housing into the care pathway and delivering flexible support to people in their homes.168

5.4 Step-down services, accelerating hospital discharge and preventing re-admissions

Transitional housing models, sometimes also called intermediate care can offer people who have had a period in hospital a transitional flat to build confidence, mobility and living skills or to wait whilst adaptations are completed on their own home. Such services reduce unnecessary hospital stays or referral to residential care.

Havebury Housing Partnership (HHP)—Hospital Discharge Service

In partnership with the NHS, HHP in Bury St Edmunds provide a flat for people discharged from hospital or waiting for completion of adaptations to their home. HHP’s weekly charge of £155 is a

165 National Housing Federation Neighbourhood Audit (2008)


166 Establishing the extra in Extra Care: Perspectives from three Extra Care Housing Providers, ILCUK report September 2011, p1

167 This is a summary of the full CSED case study, available online www.csed.dh.gov.uk/_library/Resources/CSED/CSEDProduct/shoregreen01.pdf

168 National Housing Federation, Breaking the Mould: Revisioning Older People’s Housing (2011), www.housing.org.uk/publications/find_a_publication/care_and_support/breaking_the_mould_re-vision.aspx
considerable saving on local hospital weekly bed cost of £2,800. Reduced need for registered care will also save social care budgets.

5.5 Housing with personalised care and support

Several housing associations are testing out how personalisation fits into models of specialist housing, which require a degree of stability of funding to meet core costs, which might include 24-hour cover and supervision. These models include collective purchasing by service users of a core service offer alongside a “menu” of options available for purchase from a range of providers. Sometimes called a “core and flexi” model this involves local authorities commissioning housing and support providers to deliver more individualised services within block contracts.

Look Ahead Housing & Care's Coventry Road Service

Based in London Borough of Tower Hamlets (LBTH) this is a high-needs, mental health accommodation-based service with 20 self-contained flats for clients with a range of complex needs including substance misuse, gambling addictions and forensic histories. Funded jointly by Supporting People and the PCT, the core service provides a fixed range of services required by all clients and needed to run an accommodation-based service. The flexible service provides individual support and a cash budget to enable the service to be tailored to the needs, wishes and interests of the customer.

December 2011

Written evidence from Dr James Mumford, Senior Policy Researcher, the Centre for Social Justice (SC 83)

1. Personal introduction. I have worked at the CSJ since April 2010. Between April and September 2010 I worked specifically on social care as part of our wide-ranging older age review (the remit of which is set out in paragraph 2). Since September 2010 I have been the review’s lead.

2. The CSJ's older age review. Commenced in January 2010 and completed in June 2011, the CSJ’s 18-month older age review resulted in the publication of two reports, an interim “state-of-the-nation” report in November 2010, The Forgotten Age, followed by a recommendations report, Age of Opportunity, in June 2011. The report brought together an expert working group of professionals in the field—from the chief operating officer of Anchor to a local authority adult social services director; it involved extensive evidence-gathering across the country, polling and consultation with many older people. From the outset our remit was to examine the wide range of issues which the poorest older people in England and Wales face, including but not limited to challenges in social care. It was felt strongly when we began work that to look at social care without taking into consideration issues around housing, nursing, social isolation and unpaid care distorts perspective.

3. The contextual importance of social isolation. The fundamental thesis of Age of Opportunity was that any strategy to transform the lives of the poorest older people in Britain begins with combating social isolation. Any genuinely preventative social care policy will be one that attempts to re-engage the most isolated older people living in the community.

4. Evidence about social isolation. Staggering existing statistics about social isolation—the previous Government’s estimate of a million pensioners experiencing severe loneliness—have been corroborated by firsthand testimony we received, particularly in Kent and Leeds, as well as more recently by a poll the CSJ and Independent Age commissioned from Survation. Polling 2003 single occupants aged 75 and over in December 2011, Survation found that 12% were to spend Christmas day alone, 40% of whom had children living in the UK. An even larger proportion, 18%, had no human contact on an average day. Translating to the population at large (over two million people aged 75 and over are single occupants in the UK), we estimate that nearly 250,000 people aged 75 and over spent Christmas day alone in 2011 and about 370,000 are completely cut off from community. The impact of loneliness and isolation on an individual’s resilience, so we have heard from professionals working with this group, is so profound that to stave off demand on social care services requires a much more concerted and unified effort to reach the most isolated.

5. “Vital connections” recommendations. The central policy recommendations of Age of Opportunity related to tackling social isolation were increasing the number of local partnerships between statutory agencies (including social workers) who often come into contact with the most isolated older people and charities which can provide the kind of relational support the state cannot. We profiled a number of outstanding examples of this, eg PSCOs going door-to-door introducing older people to volunteers from a befriending charity in Manchester. But this needs to happen on a far more widespread basis if real change is to occur and thus real social care prevention.

6. Recommendations relating to unpaid care. It is well recognized that many of the vast army of six million carers in the UK need more support to prevent them reaching “breaking point”. Our concern was about how the £400 million the Government has channelled towards respite care will actually reach carers on the ground (since only around a quarter of the previous Government’s £150 million did so). GPs are crucial to this process, both in identifying carers and in providing access to respite care. Social prescriptions in one GP practice in Cambridgeshire, based on close working between that practice and the local Crossroads Care, works so superbly
that many carers can quickly and easily access respite care. The CSJ recommends that this become part of GP culture.

7. The vanguard of integration: multidisciplinary teams. The CSJ was established to influence government policy affecting the lives of the very poorest in our communities. In terms of the integration agenda, the older age review thus concentrated particularly upon how health and social care professionals could work more closely to improve the lives of those older people living in both ill health and poverty. Multidisciplinary teams, based in the community, led by GPs but run by community nurses, are able to provide the kind of enhanced support which the neediest older people require. This serves to reduce the number of “portals” or entry-points people experience while remaining firmly focussed on reducing unplanned emergency admission to hospital. We believe that diverting resources away from secondary care towards community care (opening a new “virtual ward” every time a hospital ward is closed) is politically attractive.

8. Dreaming a different future for residential care. The major premise of our review in terms of residential/nursing care was that the need for care homes is not simply going to go away. While we welcome attempts to help more people stay in their own homes for longer, the prognosis around dementia alone means that there will always be a need for a larger number of older people looked after in intense care settings. Therefore, what we desperately need are bigger visions about what residential care could look like in the future. During the course of the review the CSJ undertook an international visit to the U.S. to visit the Green House model pioneered by Harvard-educated geriatrician, Dr Bill Thomas. Green Houses cater for nursing home patients but have revolutionised the context and form of care those people receive. Green Houses are smaller, more intimate facilities (designed for eight to 10 residents each) and incorporate both innovative design principles (open-planned kitchens, no long corridors, etc) and radically new staffing models (with staff more empowered to take charge of the running of the home).

9. The NHS’s responsibility for health care in care homes. Visiting dozens of both residential and nursing homes in the UK during the course of the review, one complaint regularly heard related to the difficulty of seeing GPs regularly in a long-term care setting. Many GPs attested to this. Our central recommendation, therefore, is that the system be overhauled. Rather than a plethora of different GPs visiting individual patients on a sporadic basis—leading to confusion, frequent emergency admission and poor palliative care practice—instead single GP practices should take charge of medical care of entire homes. 79% of people polled by YouGov on behalf of the CSJ agreed that individual GPs should take responsibility for all residents in a care home, allowing all residents to see a GP on a regular basis.

January 2012

Supplementary written evidence from the Department of Health (SC 01A)

During my evidence session with the Health Select Committee I promised to write to the Committee to clarify the Government position on three issues:

— the current funding position in the system;
— the totality of the measures we are taking to improve integration between health and social care; and
— the position on using personal budgets to pay for local authority services or a member of one’s family.

Attached to this letter are detailed annexes on these three areas and I have summarised them below.

With regard the current level of funding in the system, government made the decision to prioritise social care in the Spending Review (SR) and allocated an additional £7.2 billion to local government for social care over the course of the SR. It is our assessment, and this has been corroborated by The King’s Fund, that this money, combined with efficiency measures, means that there is funding available to protect people’s access to care and deliver new approaches to improve quality and outcomes.

As we discussed during the evidence session we have taken a number of measures to ensure greater integration between health and social care under the new systems. The totality of the measures is summarised in the annex and I believe that in combination they provide a very strong basis for better collaboration, partnership working and integration across local government and the NHS at all levels. We will continue to work with the Future Forum and others to drive improvements in integration between health and social care.

On the questions regarding the use of personal budgets, individuals can continue to receive local authority services with a personal budget; however, they cannot take this proportion of their personal budget as a direct payment and then use this to pay for local authority services. Individuals also cannot use their direct payment to pay for the services provided by close relatives living in the same household except in exceptional circumstances, eg if the care is particularly complex. Direct payments are not intended to replace existing support networks within families and communities.

I also said I would share information with regard the statistics I quoted on workforce satisfaction with their jobs and the work Sainsbury’s has undertaken to identify hidden carers and this information is also annexed to the letter.
I hope that this letter provides additional clarity on these important areas and look forward to receiving your report which I believe will be a valuable contribution to our thinking ahead of the care and support White Paper and progress report on funding.

Paul Burstow MP
Minister for Care Services

January 2012

Annex A

CURRENT FUNDING POSITION

In the Spending Review, government recognised the pressures on the adult social care system within a challenging settlement for local government, and took the decision to prioritise adult social care.

Available Funding for Adult Social Care

We recognised that the local government settlement was challenging. Local authorities will receive a 26% decrease in revenue grant support from central government over the spending review period—excluding schools, fire and the police. However, local authorities also gain revenue from council tax. Once projections from the independent Office for Budget Responsibility on income from council tax are taken into account, overall local government spending power on unhypothecated services (including adult social care) is projected to fall by 14% in real terms by 2014–15.

To mitigate against the potential impact of these reductions on adult social care services, the Government allocated an additional £7.2 billion over four years to 2014–15 to support the delivery of social care.

Of this additional funding:

— £1 billion by 2014–15 will be allocated within the NHS to be spent on measures that support social care, which also benefits health.

— Additional grant funding, totalling £1 billion by 2014–15, will be made available for social care. In order to support local flexibility and to reduce administrative burdens, this funding will go to authorities through the general formula grant.

<table>
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<tr>
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<tbody>
<tr>
<td>New DH grant funding for social care (rolled into formula grant—non ring fenced)</td>
<td>0.53</td>
<td>0.93</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>NHS Funding to support social care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Of which: Reablement</td>
<td>0.8</td>
<td>0.9</td>
<td>1.1</td>
<td>1.0</td>
</tr>
<tr>
<td>— PCT transfers 11/12 and 12/13</td>
<td>0.15</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>— Other mechanism for 13/14 and 14/15 to be confirmed</td>
<td>0.65</td>
<td>0.62</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

This additional funding was based on our assessment of the pressures faced by social care services, the efficiencies that authorities could achieve, and the implications of the wider reductions to local government funding.

On top of the funding announced at the Spending Review, the Department of Health allocated £162 million to PCTs in January 2011 and a further £150 million to PCTs in January 2012 to support adult social care services in reducing delayed transfers of care.

Overall Assessment

In sum, once an assessment has been made of the pressures and efficiency opportunities in adult social care, and the available resources through the local government finance settlement considered, we believe that the additional £7.2 billion means that there is funding available to protect people’s access to care and deliver new approaches to improve quality and outcomes.

This assessment was broadly corroborated by a report from the King’s Fund to the Health Select Committee’s 2010 Public Expenditure Inquiry, and replicated in its publication Social care funding and the NHS. This publication showed that, in its worst case scenario, councils will need to find efficiency savings of 3.5% p.a. to meet the demand pressures on the system.169

The Department acknowledges that there is unmet need but also that the scale of this is difficult to precisely define and measure. The eligibility framework seeks to support councils in prioritising funding on those with the highest need. Government is clear that everyone who thinks they may be in need of care and support is entitled to an assessment, and if this assessment concludes that services are required to meet the person’s assessed needs and the person qualifies under the means-test, services must be provided.

169 Humphries, R, Social care funding and the NHS (King’s Fund, 2011).
Adult social care is a locally delivered system, and local authorities are accountable to their local populations for the decisions they make. It is for local authorities to choose how best to use their available funding, not for Whitehall to prescribe how their funding should be used.

**NHS Transfers to Social Care**

As set out in the table above, the Government allocated £648 million this year to Primary Care Trusts (PCTs), to transfer to local authorities for spending on social care services that also benefitted the health system. We collected data from PCTs in September 2011, to understand how the transfer was progressing and how it had been used.

We asked PCTs how they and their local authority partners intended to use the funding. Around 18% of the funding was used for “maintaining eligibility criteria”—this suggests the funding was used for general social care capacity to ensure that demand could continue to be met.

However, there is also evidence that the funding has been used to ensure specific prevention and rehabilitation capacity in councils has been maintained. “Re-ablement services” account for a further 18% of the transfer, intermediate care accounts for 10%, early supported hospital discharge schemes 8% and integrated crisis response a further 8%. We are pleased that PCTs and LAs have priorities this upstream investment, in order to help delay or prevent downstream costs to both systems.

The following chart shows the amount allocated by category:

<table>
<thead>
<tr>
<th>Category</th>
<th>Planned transfer (£m)</th>
<th>% of total allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reablement services</td>
<td>117.425</td>
<td>18.1%</td>
</tr>
<tr>
<td>Maintaining eligibility criteria</td>
<td>115.945</td>
<td>17.9%</td>
</tr>
<tr>
<td>Other services</td>
<td>86.912</td>
<td>13.4%</td>
</tr>
<tr>
<td>Other preventative services</td>
<td>67.241</td>
<td>10.4%</td>
</tr>
<tr>
<td>Bed-based intermediate care services</td>
<td>61.185</td>
<td>9.4%</td>
</tr>
<tr>
<td>Early supported hospital discharge schemes</td>
<td>51.051</td>
<td>7.9%</td>
</tr>
<tr>
<td>Integrated crisis and rapid response services</td>
<td>50.524</td>
<td>7.8%</td>
</tr>
<tr>
<td>Community equipment and adaptations</td>
<td>31.771</td>
<td>4.9%</td>
</tr>
<tr>
<td>Mental health services</td>
<td>31.004</td>
<td>4.8%</td>
</tr>
<tr>
<td>Telecare</td>
<td>28.696</td>
<td>4.4%</td>
</tr>
<tr>
<td>Not yet agreed</td>
<td>6.247</td>
<td>1.0%</td>
</tr>
<tr>
<td><strong>Total allocation</strong></td>
<td><strong>648.000</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

We are pleased that arrangements for the transfer appear to be working well, and that funding is already flowing through to local authorities. Feedback from both PCTs and local authorities has been positive, with many areas stating that the funding transfer has stimulated greater co-operation and joint planning.

**Annex B**

**INTEGRATION**

The current reforms provide the basis for better collaboration, partnership working and integration across local government and the NHS at all levels.

**Current Reforms**

**New duties on commissioners.** The Bill places new duties on clinical commissioning groups (CCGs) and the NHS Commissioning Board to promote integrated working by taking specific action to secure integration (where beneficial to patients). CCGs will be best placed to promote integration given their knowledge of patient needs, and the commissioning power to design new services around these needs. The importance of greater integration is demonstrated by the development of more aligned health, social care and public health outcomes frameworks.

**A liberated provider side.** One of the main aims of our reforms to NHS trusts, Foundation Trusts and the role of Monitor is to stimulate and enable new models of integration to occur, recognising providers are likely to develop some of the most innovative ideas for more joined up services. There have been concerns that integration will be prevented by competition, and in response new safeguards have been introduced. Monitor’s core duty is now clear that patient interests always come first. The Bill places new duties on Monitor to support integration where it is in the benefit of patients and will be required to focus on what benefits patients over and above any potentially negative effects on competition.

**Health and wellbeing boards bring everyone together.** The Bill gives health and wellbeing boards a duty to encourage health and care commissioners to work together to advance the health and wellbeing of the local population. Health and wellbeing boards have to draft and agree a Joint Health and Wellbeing Strategy for
their local area. How different services work together around patient needs will be a key part of the strategy. The Bill places a duty on health and wellbeing boards to consider the partnership arrangements under the NHS Act (such as pooled budgets) when developing their strategy. The involvement of local HealthWatch in health and wellbeing boards will help put the voice of patients, people using services and the public at the heart of the board’s work.

Financial incentives to drive integration. We have made available funding to back this up including £648 million in 2011–12 to PCTs, to transfer to councils for spending on social care services that also benefit health.

Extending remit of NICE to social care. The NHS White Paper set out plans to extend the remit of the National Institute for Health and Clinical Excellence (NICE) to social care to support the creation of effective quality standards for all those using health and social care services. These will define the levels of quality for commissioners, providers and users. Our objective is to develop NICE so that it becomes the single, authoritative source of quality improvement material across both health and social care.

Further DH Policy Development

There is scope to progress integration further, and the centre has a role in developing metrics, sharing of best practice, model contracts and exploring new models of funding. The Department will continue to refine the policy framework, for example via the social care white paper, to ensure incentives are optimally aligned to support, enable and encourage integration in support of improved outcomes. This includes:

— Encouraging more joint commissioning—we are exploring how we encourage CCGs and LAs, via the health and wellbeing board, to commission for whole populations;
— Aligning outcomes and developing patient experience measures across whole journeys of care, spanning transitions between services and sectors;
— Aligning financial incentives in particular tariff redesign, eg unbundling tariffs, year of care tariffs, and greater investment in community services;
— Enabling individuals to drive integration—personal care budgets can be combined with personal health budgets creating a powerful force for integration at an individual level; and
— Establishing a national learning network for pathfinder CCGs—in addition to the support given by SHA and PCT clusters, national learning sets to accelerate development of health and wellbeing boards will help evaluate how well they work, their collective impact on improving outcomes, and ways of sharing learning.

The Department will shortly publish the outcomes of the Integrated Care Pilots and the Whole Systems Demonstrators programme. Both experienced benefits and challenges which we will learn from to inform the care and support white paper.

Partnership Working

In the Government’s response to the first Future Forum report, we committed ourselves to continue working in partnership with all of those helping to drive improvements in integration between health and social care.

In January, the NHS Future Forum submitted its second report to the Government. The Forum’s report, and Government Response, set out steps to maximise the potential to increase the pace and scale of integration within the current reforms. We can expect to see a step change in the scale of integrated models of care working. The “headline” recommendations are:

— Integrate around the patient, not the system.
— Make it easier for patients and carers to coordinate and navigate.
— Information is a key enabler of integration.
— You can only improve what you measure.
— Health and wellbeing boards must become the crucible of health and social care integration.
— Providers need to be able to work with each other to improve care.
— Clarify the rules on choice, competition and integration.
— Allow freedom and flexibility to “get on and do”.
— Allow the funding to follow the patient.
— National level support for local leadership is essential.

Our work with the NHS Future Forum workstream on integration is central to shaping our understanding of the relative priorities for action and informing the development of the care and support White Paper planned for the spring.

Subsequently, The King’s Fund and Nuffield Trust published their work to support the Department and the Future Forum’s work on integration. This work is closely aligned with the Future Forum report. They saw the main priorities for the future as:
— Setting a clear, ambitious and measurable goal to improve the experience of patients and service users.
— Offering guarantees to patients with complex needs.
— Implementing change at scale and pace.

ADASS and the NHS Confederation have also published a joint statement on integrated care.

“The potential for joint working across local authority and NHS services has yet to be fully exploited. We believe there are many more opportunities to make this happen in order to benefit service users and the success of integrated care should be measured through improvements in outcomes.”

Annex C

PERSONALISATION

Using Direct Payments to pay Family Members

— The Department’s direct payments guidance states that direct payments are not intended to replace existing support networks within families and communities. For this reason, direct payments may not normally be used to secure a service from:
   — a spouse or partner; or
   — a close relative that live in the same household.
— The Department’s guidance on direct payments for Community Care, Services for Carers and Children Services, 2009 paragraph 135 says:
   — “Unless a council is satisfied that it is necessary to meet a person’s needs, or, in the case of a child, that it is necessary to promote the child’s welfare, a council may not allow people to use direct payments to secure services from: a spouse (husband or wife); a civil partner; the other member of the unmarried or same-sex couple of which they are a part; or a close relative with whom they live, or the spouse or partner of that close relative.”
— In very exceptional circumstances, councils may be prepared to consider allowing someone to use direct payments to pay a close relative who shares the same household, eg where the person has extremely complex issues and can only be looked after by the family member.

Using Direct Payments to pay Local Authority Services

— Direct payments are intended to enable service users to meet their care needs through the use of services other than those which the Local authority would otherwise provide or arrange itself. However, there is no objection to service users using a direct payment to purchase services from another local authority if they are providing a service that they need that is not available locally. Another example where this may be used is by people who live close to local authority boundaries.
— If a person wishes to continue to receive a local authority service they can do so as part of their personal budget. Their direct payment would reduce to reflect this.

Annex D

WORKFORCE

During the evidence session MS(CS) quoted research stating what care workers like about their role and why care workers leave their roles. This data and the sources are set out below.

Information on what care workers like about their role is set out in the graph below. This comes from the National Survey of Care Workers research Skills for Care undertook in 2007.

It was a random sample based on 500 adult social care workers in England.
WHAT CARE WORKERS LIKE ABOUT THEIR ROLE 2007

- I enjoy the work: 31%
- I enjoy working with elderly people/clients: 20%
- I enjoy improving people’s quality of life: 18%
- Job satisfaction: 14%
- I enjoy team working/friendly staff: 10%
- Flexible hours: 9%
- Rewarding: 8%
- Varied work: 7%
- Not stated: 6%
- Other: 5%
- Enjoy providing company: 4%
- Enjoy meeting people: 4%
- Good pay: 4%

Information about why care workers leave employment is set out in the graph below. It comes from the National Minimum Data Set for Social Care (NMDS-SC) at September 2011, collected by Skills for Care. The figures are based on almost 80,000 leavers. The NMDS-SC information is completed by the employer and not the employees themselves hence one of the reason why “personal reasons” scores so highly.

The NMDS-SC allows for sector breakdowns (amongst other things) that show some interesting differences between independent sector workers reasons for leaving and those from councils.

REASONS FOR LEAVING EMPLOYMENT

- Personal reasons: 20.6%
- Transferred to another employer: 14.3%
- Other: 11.2%
- Resignation for other or undisclosed reasons: 11.2%
- Career development: 10.6%
- Dismissal: 7.3%
- Nature of the work: 6.4%
- Retirement: 5.4%
- Pay: 4.0%
- Redundancy: 2.8%
- Competition from other employers: 2.4%
- End of contract term: 1.8%
- Conditions of employment: 1.5%
- Death: 0.5%

Annex E

Carers

The Torbay Care Trust have been working with Sainsbury’s in a joint initiative to help customers with caring responsibilities to identify themselves as carers.
Sainsbury’s analysis of purchasing patterns identified that a large supermarket sees around 500–600 “double shoppers” a week—ie people who purchase groceries separately for others while doing their own shopping. Many of these customers are carers. A further number of carers can be identified through Sainsbury’s pharmacies, when picking up a prescription for somebody else.

The Torbay Initiative

The Torbay Sainsbury’s has run three short campaigns since 10 November 2010 in their local stores to help identify “hidden carers”—ie those who are not known to health and social care services.

Staff were encouraged to ask “double shoppers” if they had caring responsibilities and, if so, to point them in the direction of display stands in the supermarket foyers, staffed by local carers and Torbay Care Trust Carers team. The publicity focussed on having a Carers Emergency Card (provided free through Torbay Carers Register) which ensures that arrangements are in place to support the cared for person if the carer has an emergency and cannot return home. This service gives carers peace of mind and is highly valued by carers.

Feedback from the initiative includes:

— Over 150 people signed up to join Torbay’s Carers Register. There was a significant increase in the number of carers joining the Register in the month immediately following the campaign. Double the number joined after the first two campaigns. In an average month, about 35 carers join the Register, but for the month following the campaigns, the numbers were 74 for November 2010 and at least 68 for February 2011. These represent significant “spikes” in joiners.

— One of the stores was a small local shop rather than a large supermarket but staff were very supportive, even though space was limited and there was no room for a stand in the foyer. It suggests that it is possible to run the campaign in any store.

— In one store, eight Sainsbury’s staff joined the Carers Register during the first campaign.

— The campaigns generated significant local media attention including radio and TV (eg a feature on the main Westcountry TV news programme).

Results from Torbay

Overall more than 300 people at the stores took applications to join the Carers Register, to access the Emergency Card (and other carer support services). Torbay estimated that 50 carers joined the Register as a direct result of each campaign ie 150 new members in total. Those carers who did not join within the first month following the campaigns were telephoned by volunteer carers from the local Carers Telephone Helpline to check if they needed help to complete the application.

People who were not carers themselves took information to pass on to carers they knew.

The direct involvement of carers in the campaign and their presence in staffing the stands, raised awareness amongst the public and Sainsbury’s staff.

Next Steps

Following on from this piece of work, DH had been in discussion with Sainsbury’s HQ about rolling out the initiative further in spring this year. In the first instance, it has been agreed to test the approach across 14 Sainsbury’s stores in the London region to look at the effect on stores’ productivity.

Supplementary written evidence from the National Housing Federation (SC 82A)

Introduction

The National Housing Federation is the voice for affordable housing in England. Our members provide two and a half million homes for more than five million people. Every year they invest in a diverse range of neighbourhood projects that help create strong, vibrant communities. Approximately half of our members deliver housing, care and support services to some of the most vulnerable people in society, including people with learning disabilities, people with mental health problems, older people with care or support needs, homeless people, and women fleeing domestic violence. The wide range of services provided includes: help in setting up and looking after a home or tenancy, support with developing independent living skills, help to develop social networks, manage money and to stay healthy and access health services, and assistance to arrange repairs and home improvements as well as social care.

Federation chief executive David Orr gave oral evidence to the committee on 10 January 2012. During the evidence session, David mentioned he would provide the committee with additional information to supplement his answers. Some of this is captured in separate documents:

— Our report on improving the offer for older people’s housing, Breaking the Mould.170

170 http://www.housing.org.uk/publications/find_a_publication/care_and_support/breaking_the_mould_re-vision.aspx
Impact of Under-Occupation Measures in the Welfare Reform Bill

In February the Welfare Reform Bill will return to the Commons and MPs will have the opportunity to protect an amendment that will make a difference to the lives of over half a million families in social housing across the country.

Under measures in the Bill, 670,000 households were set to be hit by a bedroom tax, averaging £670 every year, because they were deemed to have one or more extra bedrooms. However, in December, peers voted overwhelmingly in favour of a cross-party amendment to exempt those families with just one additional bedroom where there are no alternative properties for them to downsize to.

The Government plans to use the Welfare Reform Bill to cut the housing benefit of any working-age social housing tenant deemed to be “under-occupying” their social home. Under its social sector size criteria, anyone with one extra bedroom would lose 14% of their housing benefit (on average £12 per week) and those with two or more would lose 25% (on average £22 per week).

The House of Lords’ compromise amendment ensures the Government’s proposals are targeted at the type of high level under-occupation that provokes wider public concern. Crucially, it recognises that there are simply not enough smaller homes into which social tenants can downsize.

Modelling by the National Housing Federation has found that while 180,000 social tenants in England are “under-occupying” two-bed homes, only 68,230 one-bed social homes became available for letting in 2009–10. The lack of mobility in the sector is not a product of tenants needlessly under-occupying larger homes, but rather the log-jam created by a national shortage of affordable homes, and in particular one and two bedroom properties.

Without the amendment the Government’s proposals will have disastrous implications for a huge number of people already struggling to make ends meet. It will ensure that households that have nowhere else to move to are not financially penalised for having:

- A bedroom to permit overnight “access” visits by children following marital breakdown.
- A bedroom used by a disabled child who needs care during the night and cannot share with a sibling.
- Couples who use their extra bedroom when recovering from an illness or operation, or who need to sleep separately for medical reasons.
- Separate bedrooms for teenagers of the same sex who, for example, may be studying for exams.
- An additional bedroom to enable families to foster children.

The DWP has claimed, incorrectly, that the compromise amendment would reduce its savings by £300 million. In the debate, Lord Freud accepted that it was not possible to quantify its effect, because any estimate depends on how many households are able to downsize. The DWP’s claim assumes that almost every tenant with one extra bedroom would be unable to find alternative accommodation. This will not happen, nor should Government want it to if the policy’s aim is to encourage people to downsize.

Effective Adaptations

Housing associations recognise the need to work with local authorities to meet the demands for aids and adaptations and to provide an effective and good quality adaptations service.

Many housing associations feel the current system for funding and fitting adaptations has led to patchy access to the Disabled Facilities Grant (DFG) among tenants and extensive delays to delivery due to the priorities of the local authority and the availability of funds. Of the 355 housing authorities in England, nearly all have different policies regarding the funding of adaptations in housing association properties, which are mainly based on the level of resources they have allocated to adaptations and how adequate those resources are to meeting demand. In order to deliver an effective adaptations service, it is important that the local allocations process works with a register of adapted properties, particularly through choice-based lettings—a system which allows customers to “bid” for a particular property, which is openly advertised.

Otherwise adapted properties can remain empty or expensive adaptations have to be removed, even though three-quarters of a million people aged 65 and over need specially adapted accommodation because of a medical condition or disability.172

171 http://www.nhsconfed.org/Publications/Documents/Housing_MH_021211.pdf
172 Housing in England 2006/07, Department for Communities and Local Government, 2008
Falls represent over half of hospital admissions for accidental injury. Half of those with hip fracture never regain their former level of function and one in five dies within three months.\textsuperscript{173}

Over two-thirds of people over 85 in the UK have a disability or limiting long-standing illness. Currently around 3.9 million older people have a limiting long-term illness, rising to 5.5 million in 2025.\textsuperscript{174}

Case Study—South Staffordshire Housing Association

Mrs Edna Lawton had lived in a home owned by South Staffordshire Housing Association for many years. At 94, she had become frail and gave up using the bath to wash because she felt unsafe. She was then forced to wash at the sink, which took her over half an hour every day. Soon after an assessment with the occupational therapist, a walk-in shower was fitted for Edna making her life so much easier. Throughout the process, Edna had clear information about who was responsible for the work and how they could be contacted to minimise the stress and disruption to her everyday life.

South Staffordshire Housing Association’s Project Independent Living means that the waiting list for minor adaptations has been cut from twelve months to seven days. This service has become possible because of the partnership created between the housing association, its tenants, South Staffordshire District Council and Staffordshire County Council.

After assessing their service, South Staffordshire Housing Association found that delays occurred when, for both funding and medical reasons, applicants needed to be assessed by an occupational therapist before work could start. To add to the frustration, applications, assessments, commissioning work and fitting equipment were each being done by different agencies. Applicants didn’t know where they were in the system or who they should be chasing for information.

South Staffordshire Housing Association approached the local authority with the solution that they became the first and only point of call for applicants. They commissioned an occupational therapist who, as well as doing assessments for major adaptations, trains their staff in assessing for minor aids. This has cut waiting times and the partnership with the local authority has reduced costs for major adaptations from £7000 to £4200, a 40% reduction.

South Staffordshire Housing Association is also building a pool of housing stock with adaptations. They have produced an integrated register of people with disabilities and homes with adaptations. This means that where a property does not lend itself to adaptation, they can advise residents of where there is a vacancy which may suit their needs.

This case study is taken from the Federation’s report, \textit{In Your Lifetime}. (2010)\textsuperscript{175}

\textit{January 2012}

\textsuperscript{173} Help the Aged, Don’t Mention the F-Word, 2005

\textsuperscript{174} POPPI data, taken Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S016 Sex and age by general health and limiting long-term illness

\textsuperscript{175} http://www.housing.org.uk/publications/find_a_publication/care_and_support/in_your_lifetime_a_vision.aspx