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).

Contacts

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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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Written evidence

Written evidence from FirstStop Advice for Older People (SC 02)

FirstStop Advice for Older People brings together the expertise of some of the most trusted and respected organisations in the UK providing a one stop national and local advisory service able to deliver advice and information in the four areas which most older people will need to visit at some time:

- **Care**—Advice about care in any setting from your own home to a care home.
- **Housing**—Advice about housing options from adapting your own home or choosing retirement housing to care homes, including searchable databases of UK accommodation.
- **Finance**—Advice about money including benefits, grant funding and independent financial advice for meeting the cost of care and releasing equity.
- **Rights**—Advice to help older people get the help, care and support they need when they need it.

With one telephone number and one website FirstStop is a single gateway to free, independent advice and information to equip older people, their families and carers to understand their rights and options and make informed decisions about care, housing and finance.

The Submission below focuses on just the funding aspect of social care and the recent report from The Commission on Funding Care and Support. It aims to highlight issues around the recommendations that to be resolved.

1. **The £35,000 CAP**
   - This is calculated based on the weekly amount the local authority would be prepared to pay for your care if they were providing it, not on the actual cost of the care.
   - The cap excludes accommodation costs.

**Issues to be resolved**

- Once you reach your cap the local authority would assist with your care costs but only up to the amount they would usually pay for someone with your assessed needs. If the care you have chosen, or wish for exceeds that cost you will be required to find a third-party to top-up the cost. Present law, through guidance, does not permit individuals to fund their own top-ups.

- If the aforementioned top-up law was changed to permit individuals using their capital below the means test threshold then there is a danger that care providers would be less likely to accept any residents at local authority rates.

- Currently your home is disregarded as capital as long as you continue to occupy it therefore, if your savings are below £23,250 the cost of any home care you need would be provided to you by the local authority and counts towards your cap. For example if you were to move into a care home after receiving say £20,000 worth of home care from the LA your cap would be reduced to £15,000. However, if you are unfortunate and need to move straight into a care home when needing care, your property is counted and your cap is £35,000.

2. **The Increase in the Means Test Threshold to £100,000**
   - Once your capital is depleted to £100,000 the local authority will assist with the funding of your £35,000 cap.

**Issues to be resolved**

- The tariff income you would have to pay between the lower threshold of £14,250 and the higher of £100,000 is £1 for each £250 therefore on £100,000 your tariff income would be £343 per week plus your accommodation costs of £200 per week (£10,000 per annum) equates to £543 per week or £28,236 per annum.

- If the care home costs the average which the Commission quotes as £28,600 per annum then the local authority contribution would be just £364 per annum (£7 per week).

- If the local authority are contributing towards your care costs (albeit £7 per week) you would cease to be eligible for attendance allowance losing £73.60 per week so effectively £66.60 out of pocket, or £3,463.20 per annum. This makes the true cost of £28,600 worth of care to the individual become £31,699.

- If the care home provides nursing care then, according to Laing & Buisson the average cost is £190 per week more. The NHS nursing care contribution is currently £108.70 per week therefore leaving a further £81.30 of what should be an NHS responsibility being funded by the individual or the local authority.
3. **Accommodation Costs to be Set at Around £10,000 Per Annum**
   - The median net income of single people aged over 65 is £11,284, which, after subtracting the Personal Expenses Allowance (PEA), means that around half of older people should be able to afford a contribution of £10,000 out of their incomes.

   **Issues to be resolved**
   - After paying £10,000 accommodation costs the individual is left with just £1,284 (£24.69 per week to cover their personal expenses. The current Personal Expenses Allowance (PEA) is £22.60 per week. For a number of years it has been argued that the PEA should be set higher at around £40 per week.
   - Some care providers are likely to demand a higher figure for accommodation but this could only be met by individuals who are free to meet this cost because they have capital in excess of £100,000 and are permitted to top-up.
   - If care providers are forced to keep within the £10,000 cap for local authority funded residents then the are likely to continue the practice of charging self-funding residents considerably more to subsidise their local authority funded residents.

4. **Setting the Eligibility Threshold to Substantial**
   - It is recommended that the eligibility threshold for public supported care should be set at a minimum of “substantial”.

   **Issue to be resolved**
   - This does not contribute towards the preventative agenda and could prove to be a false economy. The existing low and moderate needs of people is defined as: Moderate—there is a risk to independence harm or danger either now or in the next 12 months. Low—there is a low risk to independence. There is strong evidence that unmet need for these people can lead to hospital admissions and/or substantial and critical need.

5. **The Government should Develop a Major New Information and Advice Strategy**
   - It is critical that the public has access to better, easy-to-understand and reliable information and advice about services and funding sources.

   **Issue to be resolved**
   - Much of this work has been done with the Department for Communities and Local Government funding the start up of FirstStop Advice both nationally and locally integrating advice and information around housing, care, health, money and rights. www.firststopadvice.org.uk an independent evaluation of FirstStop Advice has been conducted by Cambridge University, Cambridge Centre for Housing & Planning Research http://www.cchpr.landecon.cam.ac.uk/

6. **Those Entering Adulthood with Already Established Care and Support Needs should be Eligible for Free State Support**
   - People born with a care and support need or who develop one in early life cannot be expected to have planned in the same way as older people.

   **Issue to be resolved**
   - There will be a proportion of such people who could inherit substantial wealth or may have received substantial compensation to assist with their living costs and coping with disability. If these people could afford to contribute should there be a capital threshold to free state support?

7. **The Government should Review the Scope for Improving the Integration of Adult Social Care with Other Services**
   - Adult social care needs to be integrated with housing, health, money and rights.

   **Issues to be resolved**
   - Aligning adult social care with the NHS service would cost considerably more but would be worth it to fix the existing system and meet unmet need.
   - The cost for delivering an aligned system could be borne by each generation in different ways see: Joseph Rowntree Foundation Report http://www.jrf.org.uk/publications/funding-care-fair-share.
IN CONCLUSION

In conclusion, how the different political parties react to the Commission’s report remains to be seen but clearly the recommendations do not resolve the main issues which are that we have an underfunded, underperforming social care system on the brink of collapse which cannot be funded by future generations. The Commission’s remit was to look at the existing and future demand for care and support, look at the unmet need, look at the failings and inconsistencies of the existing system and look at the complexities of the charging structure, this the commission has done but it has not come up with an equitable and sustainable solution whereby each generation pays for its own care collectively. Needing care and how much it will cost you remains a lottery.

There still exists the opportunity for Government to be brave and come up with an equitable solution where each generation pays for its own care through taxation of assets of the older generation and through building a compulsory insurance fund for the younger. In both the latter the opportunity exists to create pots of money that if ring-fenced can enable the means test to be scrapped, our social care system aligned with the National Health Service and care and support to be delivered to all regardless of age or means, where and when it’s needed.

September 2011

Written evidence from Dr Nigel Dudley LLM FRCP, Consultant in Elderly Medicine (SC 03)

INTRODUCTION

1. This submission of evidence from Dr Nigel Dudley is made in a personal capacity. I have been working in the NHS since 1984. I was appointed to a consultant post in elderly medicine in 1993 at a time when there were still long stay geriatric wards and hospital respite care was routinely offered by the NHS.

2. I have an interest in Continuing Healthcare (CHC) funding and the use of the 2009 national guidance and decision support tool (DST) for the identification of the boundary between social care and health care. I have personal experience of applying for CHC funding for a relative and going through the appeals process up to, and including, the Parliamentary and Health Service Ombudsman.

3. My submission will focus on Recommendation 51(5) of the Law Commission’s report and the need for the Secretary of State for Health to clarify where exactly the line should be drawn between health and social care. It will also cover how the current DST could be better employed to determine eligibility for NHS funded care.

4. The chairman of the Health Committee, Mr Stephen Dorrell, MP was reported by the BBC in September 2010 as stating that people are now being charged for care that was previously received free of charge with this change having taken place without any proper debate. The Health Committee’s inquiry into Social Care is an opportunity to have such a debate and to clarify the location of the dividing line between health and social care. In any new system of social care, means-tested individuals and local authorities should not be picking up the bill for care that in fact should be fully funded by the NHS through the taxpayer and public purse.

SUMMARY

— There is a wide variation across England in levels of CHC funding per 50,000 population as recorded by the Department of Health’s own figures.

— In order to produce such variation, the professional judgment and use of the DST would seem to be flawed, with there being a failure on the part of professionals to take into proper consideration the limits of what can be lawfully provided by a local authority.

— Recommendation 51(5) of the Law Commission calls on the Secretary of State and Welsh Ministers to clarify “what combination of needs would make a person eligible for NHS continuing healthcare”.

— Paragraph 11.7 of the Law Commission’s report states “Cases qualify for NHS continuing healthcare according to formulae which weigh the severity of the cases across the different domains”. It would be possible to develop a fair scoring system from these “formulae” to bring more consistency to CHC decision-making and better clarify the line dividing health and social care.

VARIATIONS IN FUNDING: REASONS AND CONSEQUENCES

5. Gill Ayling, Deputy Director, Social Care, Local Government and Care Partnerships, wrote in her 14 July 2011 letter to Strategic Health Authority (SHA) CHC leads and others that the key aim of the National Framework for NHS Continuing Healthcare (NHC CHC) funding “was to promote consistency in eligibility across all PCTs”. In her opinion, “Real progress has been achieved, both in terms of a rise in the number of people in receipt of NHS CHC, and in terms of greater consistency in eligibility levels across England.”

6. The facts tell a different story and although, according to Department of Health figures for England, there has been an overall rise in the numbers in receipt of CHC funding (from 44,924 in Q1 2009–10 up to 53,466 in Q1 2011–12) there are parts of the country where CHC numbers have fallen. For example, in the affluent...
South Central SHA area covering Oxfordshire, Buckinghamshire, Berkshire and Hampshire the numbers in receipt of funding fell by over 1,000 from 3,999 in Q1 2009–10 to just 2,930 in Q1 2011–12.

7. The claim of a greater consistency in eligibility levels across England also does not stand up to scrutiny. In England in Q1 2011–12, the number of people being given CHC funding ranged from 75.4 per 50,000 population in the North East SHA area down to 36.7 per 50,000 in South Central SHA, a spread of 38.7 per 50,000 population. By comparison, in Q1 2009–10 the range was from 58.8 per 50,000 in the South West SHA area down to 24.6 in the East of England SHA area, a spread of just 34.2 per 50,000. Within SHAs there is also great variation in funding levels between nearby and similar sized cities. For example, the latest figures show that in the Yorkshire and Humber SHA region, Sheffield PCT funded 131.4 per 50,000 whereas Leeds PCT only funded 54.9 per 50,000.

8. Such wide variations in funding around the country are not able to be explained by the makeup of the local population. They most likely result from an inconsistent and incorrect application of the national framework and DST by local professionals who are often employed by PCTs and could be subjected to the subconscious bias of local funding pressures.

9. Flawed decision-making does have consequences. This can lead to much unhappiness with decisions being challenged and appealed at a local PCT level, a regional SHA level and a national level. Between April 2010 and March 2011 the Ombudsman received 371 complaints relating to CHC funding (figures obtained by a FOIA request). These are likely to be the tip of a very large iceberg of complaints and challenges to PCT funding decisions. This problem has been recognised and the Law Commission points out in paragraph 11.11 of its report that “a whole industry has been established which is dedicated to trying to interpret and implement the dividing line between health and social care, which consequently costs a significant amount of money to administer and police.” Clarification of the dividing line would be a way of saving money and easing the unhappiness of a considerable number of people often at a time of great stress when relatives enter a care home.

CHC ELIGIBILITY AND THE USE OF THE DST: A POINTS-BASED SCORING SYSTEM

10. Although the Law Commission in Recommendation 51(5) calls for regulations to establish an eligibility framework and specify what combination of needs would make a person eligible for NHS continuing healthcare funding, it would be possible to adapt the current DST to limit the variation between PCTs.

11. The “formulae” referred to in paragraph 11.7 of the Law Commission’s report relate to the guidance in the DST about professionals making a recommendation on CHC funding eligibility. The DST has 12 domains with the levels of need ranging from no need up to a priority level of need in four of 12 domains. Within the domains, the levels of need when present are described as low, moderate, high, severe, or priority.

The DST indicates that a clear recommendation by professionals for NHS continuing healthcare funding eligibility would be expected with:

A. a priority level of need in any of the four domains; and
B. a total of two or more severe levels of need across the 12 domains.

In addition, the DST identifies that a primary health need and eligibility for CHC funding could exist if:

A. one domain is recorded as severe, together with needs (at an unspecified level) in a number (unspecified) of other domains; or
B. a number of domains with high and/or moderate needs. (The number is not specified in the DST. However, the Directors of Adult Social Services (ADASS) and Local Government Association (LGA) October 2007 commentary and advice for local authorities on the CHC national framework indicates in paragraph 5h, page 17 that two or more high levels together with three or more moderate levels should normally be considered to be beyond the scope of LA provision).

The DST guidance also indicates that low level needs can add to the continuity of care that is necessary in someone and that low levels in all domains would be unlikely to indicate eligibility for CHC funding. However, the DST “formulae” do not state that it would be impossible for low level needs alone to add up to an intensity of care indicating a primary health need and thus eligibility for CHC funding.

12. A point scoring system based on the levels of need in the domains may clarify who is, and who is not, eligible for NHS CHC funding. At the same time it would leave less scope for the professionals to make idiosyncratic decisions that do not comply with the guidance or with the lawful limits of social service responsibilities. It would help to bring fairness and consistency to the decision-making processes and ensure that the right person or public authority was paying for care at the right time.
13. The following table shows how points could be allocated to each level of severity so as to operate a points-based system for determining eligibility for NHS CHC funding.

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<th>Level of severity of need</th>
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<td>Priority</td>
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<td>Severe</td>
<td>6</td>
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<td>High</td>
<td>3</td>
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<tr>
<td>Moderate</td>
<td>2</td>
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<td>Low</td>
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<td>No need</td>
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Anyone scoring 11 or more points would be deemed as having a primary health need and would be eligible for NHS CHC funding unless there were clearly reasoned and documented exceptional circumstances. The total of 11 points would be indicative of an “intensity” of care (in terms of quantity, severity and continuity) equating to a primary health need. With point scores over 11, it is likely that the “nature” and “complexity” of an individual’s needs would also be indicative of a primary health need.

14. The scoring system would cover the “formulae” given in the DST and would take into consideration the previously expressed limits on what could be lawfully provided by a local authority:

A priority level would score the required 11 points.

Two severe levels would score 12 points.

A severe level of need would require at least two additional needs among the remaining 11 domains to exceed the 11 points required. For example, a severe level in one domain, with a high level in the second domain and a moderate level in a third domain would give a total of 11 points. This would fulfil the requirement for a severe level with needs “in a number of other domains” as stated in the DST.

The local authority suggested lawful limit of two high levels and three moderate levels would score a total of 12 points.

Having a low level of need in 11 or 12 domains may make someone eligible for CHC funding (11 or 12 points would be scored).

15. This points-based system may help bring a greater degree of transparency to CHC decision-making. It may also assist in clarifying where the line is to be drawn between social and health care. It could lead to a reduction in the complaints and challenges to the CHC funding decisions made by PCTs and produce a fairer and less costly application of the 2009 national framework. Finally, it could avoid the need for the Secretary of State for Health to produce regulations and a new eligibility framework for NHS continuing healthcare funding.

October 2011

Written evidence from the English Community Care Association (SC 04)

1. Introduction

1.1 The English Community Care Association (ECCA) is the leading representative body for community care in England. Members provide a wide range of services; residential and nursing settings for adults, domiciliary and housing support. Member providers are small individual concerns and large corporate organisations both charitable and commercial. ECCA campaigns to ensure the optimum environment exists for independent care providers to give high quality care for those who wish and need it.

2. Issues

Policy and practice

2.1 The Government’s policy for social care and particularly its commitment to personalisation and user and carer driven services is to be applauded. Where the Government is failing is in offering leadership about acceptable models for delivery.

2.2 There is an opportunity with personal budgets and user-directed services to reconfigure the way in which local authorities commission care and it is our view that if the primary relationship is between the service user and the service provider then much of the current structure that exists in local authority commissioning should be dismantled.

2.3 There is a mismatch between the policy and the rhetoric of government and the delivery of this agenda at a local level.

2.4 ECCA supports the Law Commission’s recommendations which seek to consolidate the law on social care and give a clearer and greatly simplified legal framework within which social care can operate.
Ev w6  Health Committee: Evidence

The Dilnot Commission

2.5 We are supportive of the proposals that have been delivered by the Dilnot Commission. They clarify the relationship between the individual and the state and they also advocate for additional resources in social care. In many ways, the Commission could have been more ambitious in advocating for a higher level of resource input into social care, but it is ECCA’s view that the proposals as framed provide a better foundation for the future development and sustainability of the social care market.

Access

2.6 The amount of regional variation, both in the service offering and access to care across the country is unacceptable. If we are going to move towards a universal and agreed consistency of assessment to social care there has to be far more rigour about the approach to access and delivery. This is not to say that there cannot be regional variations, but these must be justified by an analysis of particular needs in an area.

2.7 Some local authorities, by their poor funding of social care, are stifling social care development in their area and this is leading to a reduced choice for people in that locality. For example, I have heard some independent providers who have given me a list of local authorities where they say they will not develop any care services because of the levels of funding and the attitude of the local authority in that area.

Ageism

2.8 Access to social care is inherently ageist and older people receive far less generous funding, but they also have much more narrow horizons set for them in the assessment and delivery process. The approach that is prevalent in younger adults’ services, such as enabling community engagement, wellbeing and personal fulfilment, as well as services, is missing in a lot of older people’s assessments and services.

Personalisation, personal budgets and direct payments

2.9 ECCA supports wholeheartedly the Government’s desire to move to personalised care services, personal budgets and direct payments. This move should ensure that services meet the needs of individuals and that individuals are in the driving seat of devising their care plans and negotiating any trade-offs.

2.10 We believe this will greatly enhance outcomes and the efficient use of resources, though it should be acknowledged that in every other sector of the economy bespoke and personalised services cost more and social care does not live in a parallel universe, so for some service users personalised care will be more expensive.

Portability

2.11 ECCA believes there are significant barriers to people moving from one location to another. Even if we have a standardised assessment process there are significant variations in service delivery patterns and market development across the country. There is also a great deal of negativity to geographical movement by service users and local authorities are not facilitative in the majority of cases.

Economic regulation

2.12 There is a need for economic regulation to ensure that services are sustainable. However, the focus of this should not only be about the sustainability of the business when it is first registered, but should also take account of whether or not it is a viable business going into the future.

2.13 Within the legislation that currently exists, the CQC have, under regulation 13, a role as an economic regulator and it is ECCA’s view that this power delivered properly should be sufficient and we are lukewarm about further tiers of regulation which will add expense, without proportionate benefit.

2.14 It is important to recognise that care is not a traditional market. It is controlled in large measure by the monopsony commissioning practices of local authorities. The issue about financial viability rests to a large extent with whether or not local authorities pay the true costs of care.

2.15 There is also a need to ensure that all services, whether statutory or independent, have the same viability regime. Currently, there are many services in the statutory sector which would collapse and be financially unviable were it not for the fact that the commissioning authority, who is also the provider, pays more for its own services than it is willing to pay in the independent market.

Integration between health and social care

2.16 This Government, along with many of its predecessors, has made commitments to integration between health and social care. However, the reality is, that if you have two systems with two budgets, one part of which; health, has been protected and the other part; social care, is inadequate to meet need and not ring fenced, you are going to get turf wars between different parts of the system and the social care budget raided when local authority funding is under pressure.
2.17 The Government needs to commit itself to addressing the integration problem in ways that are real rather than rhetorical. They should incentivise integrated approaches between health and social care and punish silo behaviour.

3. Conclusion

3.1 With demographic change and increased expectations, the fundamental problem of social care is that it is grossly underfunded and it is doing things which should properly be the remit of healthcare. Many people in the social care system have long-term conditions and it is difficult to differentiate their healthcare needs from their social care needs and this leads to one bit of the system trying to shunt costs into the other.

3.2 It is ECCA’s view that the Law Commission changes and the recommendations of Dilnot are the start of a process that needs to look at a radical and incremental change in the interface between health and social care. We need a frank debate about the ability of Social Care to deliver more services, particularly sub-acute provision, where the costs are significantly reduced, but the quality and the outcomes to service users and the system are good.

October 2011

Written evidence from the Chartered Insurance Institute (SC 06)

Executive Summary

— As the world’s largest professional body for insurance and financial services with over 100,000 members, the CII is committed to protecting the public interest by guiding practitioners in the sector towards higher ethical and technical standards.

— Given this remit, the CII is particularly interested in the role that appropriate financial advice and insurance can play in supporting those needing long-term care (LTC). For this reason, our evidence is limited to the proposed new funding arrangements set out by the Dilnot Commission.

— Dilnot’s recommendations are a good start—setting out a fairer approach to the funding of LTC which will, if implemented, help prevent self-funders spending the majority of their assets on paying care home fees. The proposals would also provide improved incentives for the development of financial products such as immediate needs annuities, and could lead to greater demand for financial advice as the cost of care becomes clearer.

— However, on its own a new funding model cannot resolve the chronic problems of a lack of consumer awareness and engagement which will, if left unresolved, deter people from adequately protecting their assets through financial services as they grow old. From the CII’s perspective, there are three areas in particular where more effort must be made to reverse these detrimental behavioural trends.

— Political consensus on the LTC funding model is crucial. Government and opposition must do their best to provide certainty about future rules—making cross party support for the eventual settlement vital.

— Trust is a key issue and the financial services sector must embrace reforms aimed at improving levels of public confidence in financial services and products. Similarly, those with an interest in raising the level of consumer trust and engagement must do more to improve public awareness about efforts to professionalise financial services.

— Education and easy access to understandable information is also important. In this regard, we would support Dilnot’s call for a government-led education campaign.

— There is general consensus that the current funding system is outdated. Now all interest groups must ensure that the momentum for reform created by Dilnot is sustained, and a new lasting settlement formed, which delivers much improved financial security and peace of mind for our elderly as well as for future generations requiring care.

About the CII

The Chartered Insurance Institute is the world’s leading professional body for insurance and financial services with over 100,000 members in more than 150 countries. We are committed to protecting the public interest by maintaining the highest standards of professional and technical competence as well as ethical conduct. We are a not-for-profit organisation governed by a Royal Charter, which sets out our public interest remit “to secure and justify the confidence of the public and employers” in the profession.¹

We promote the highest standards of professionalism for the financial services community and we do this in part by setting exams and awarding qualifications to financial services practitioners at the Certificate, Diploma and Chartered levels. We also require our qualified members to sign up to a Code of Ethics and undertake annual continuing professional development, both of which we enforce through disciplinary measures.

¹ Chartered Insurance Institute, Charter and Bye-Laws, Art 3(a).
THE LTC FUNDING PROBLEM

Unfair to those with modest incomes

1. Under the current system most individuals have to pay something towards the cost of LTC. The current rule is that anyone with assets worth £23,250 or above will be expected to pay for their care needs and the value of any property owned is included in most cases. There are important exceptions to this rule, such as if there is a surviving spouse living in the house, or if the homeowners alter the terms of property ownership. There is also state support to help cover nursing home fees including Attendance Allowance and a Registered Nursing Care Contribution. Nevertheless, even with these additional forms of State support, a large proportion of the population are expected to cover a substantial chunk of LTC costs.

2. The current funding model has come under significant criticism for providing too little support for those with only modest wealth with many spending a significant proportion of their assets when paying for LTC. Research from the Local Government Intelligence Unit has found that a quarter of self-funders run out of money and ultimately fall back on the State to support their care needs.

3. Another drawback of the means-tested system is that it reduces the incentives for individuals to accumulate assets and savings to pay for retirement. James Lloyd of the Strategic Society Centre has argued that a system where some pensioners must pay “catastrophic costs” for care, “does much to undermine pension saving”.

Limited supply and demand for LTC financial products

4. Since care is not free at the point of use, there is a market (albeit limited) for financial products to help fund care. There are two types of financial products specifically for this purpose, one of which must be purchased in advance of needing care (such as prefunded LTC insurance), and the other purchased once the need for care has become established (such as immediate needs annuities). Unfortunately, whilst a number of products exist, take-up has been low—particularly for pre-funded schemes.

5. Low take-up of LTCI is mainly due to demand side barriers including the cost of the products, uncertainty over the availability of care, ignorance of the risk of needing care, inertia and the complexity of products. Reputational issues also act as a barrier to equity release schemes, stemming from the consumer detriment caused by previous products.

6. Trust in financial services in general is relatively low, as was well documented in a survey undertaken by the CII in late 2010. It found that one in five respondents will never trust financial services again and 72% of people have not very much trust or no trust at all in financial advisers and life insurance providers.

7. Therefore, when delivering a future funding model which is not free at the point of use, the Government and industry must address issues associated with the fairness of the system (such as the potential for those with only modest wealth to lose the majority of their assets) and the engagement barriers that exist to deter people from seeking private sector solutions which can help to pay for care whilst protecting key assets.

WHAT ARE THE POLICY IMPLICATIONS OF DILNOT

8. The most notable proposals are to cap some of the costs of LTC and to increase the asset threshold at which people become eligible for state support. Here are however, two significant barriers to implementation of these recommendations: one is cost; the other is whether an appropriate financial services market can take root.

Cost

9. In our view, the cost of any proposals to reform LTC funding should be viewed in the wider policy context of pensions reform. Many developments are taking place in this area, of which arguably the most important is automatic enrolment bringing an estimated eight million people into formal long-term saving. As mentioned above, the current LTC system does much to undermine pension saving as only those with minimal wealth are guaranteed some state support.

10. By moving to a system where costs are capped, individuals can preserve a greater proportion of their assets providing an incentive to accumulate wealth over the long-term. A well designed LTC funding model could therefore complement pensions reforms such as auto-enrolment—helping to ensure that less people require State provided top ups to pension income in retirement.

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2 Emma Simon (July 2009), Long Term Care: How to Beat the Meanest of Means Tests, Telegraph.
5 James Lloyd, (February 2011), Gone for Good?: Pre-funded Insurance for Long-term Care, The Strategic Society Centre.
6 CII (February 2010) What we talk about when we talk about trust, p 12.
7 Pensions Policy Institute (Jan 2011), Towards more effective savings incentives: a report of PPI modelling for AEGON estimates that the introduction of auto-enrolment will significantly increase the number of individuals saving in a pension from 14 million in 2012 to around 22 million by 2015.
A renewed market for financial services?

11. Since publication of Dilnot’s final report, James Lloyd has published arguably the most extensive piece of analysis on the report’s recommendations. He questioned the ability of insurance providers to price care policies under the proposed new system. He argued that insurers can only price such policies on the basis of trends in disability and longevity yet under the “capped cost model” a “person’s £35,000 liability is determined by the availability of informal care and how much a council gives individuals with a defined level of need”. Lloyd argues that these additional elements are things insurers cannot price for.

12. Lloyd also picks up on the Commission’s recommendation for an extension to the current deferred payments scheme which allows local authorities to pay an individual’s care bill if they cannot afford to do so without selling their home. The local authority then recoups the money when the house is sold. The Commission believes it sensible to roll this out nationally and allow local authorities to charge interest to remove the disincentive they currently face in promoting the scheme. Lloyd argues that one effect of this proposal may be to crowd out the equity release market.

13. It seems then, that whilst the proposals may give the private sector more of an opportunity for involvement than previously, this may be limited to a few products that are purchased at the point of use rather than pre-funded schemes. Lloyd estimates that the number of self-funders using immediate needs annuities may increase from 6% of self-funders to 20%. A key determinant however, of whether financial products become a widely used solution to fund care, is whether there is sufficient consumer demand which is also, in part, a function of consumer awareness and engagement.

PUBLIC AWARENESS ABOUT FUNDING LTC COSTS

Cost

14. According to one previous consumer survey nearly eight in ten people have no idea how much they will have to pay for care in old age. A separate study commissioned by the Local Government Association found that 63% of individuals wrongly estimated the average cost of a care home as less than £25,000 per year. And a survey for the Department of Health found that 54% of the public think that care services are free at the point of use.

Will the proposed model close this perception gap?

15. The proposed funding model should help to close the perception gap by increasing the State’s contribution towards the provision of care relative to the individual’s—bringing it more in line with people’s expectations that the State covers most of the costs. Similarly, fixing the maximum amount that people will have to pay towards their own basic care needs should improve awareness of personal responsibility and, to a certain extent, reduce complexity.

Planning for care

16. Few have begun to think about how they will pay for LTC. A 2008 poll found that 87% of people had not made any plans to pay for personal care in older age, while just 5% of people had plans already in place. Only 6% said that they were currently arranging plans to finance their care. Similarly a survey conducted by ICM for the BBC found that more than two in five people had not made any plans for care in their old age. Perhaps these results are unsurprising given that many individuals believe the State will foot the bill when they need care. The proposed funding model may help in this regard by setting a clear limit on what an individual needs to contribute.

17. Worryingly however, many people do not even know where to begin when looking for advice on LTC. One poll of the over 50s found that a quarter of the population have no idea who to contact for advice. Only 11% said they would contact their local authority while 13% said they would contact a financial adviser.

Insurance to fund care

18. Just one previous consumer study has looked at what incentives may encourage people to contribute to an insurance scheme to fund their social care needs (it only looked at London and was therefore not necessarily representative of the nation as a whole). Over half the respondents agreed that “matched contributions” from the Government would encourage people to participate—making it the most popular of the suggested options.

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8 See J Lloyd (Aug 2011), The First Step? A Response to the Commission on Funding of Care and Support, The Strategic Society Centre.
10 ICM and BBC (2010) 77% oblivious to social care cost.
11 Local Government Association (March 2009) Call to make the care of our ageing population a priority for all political parties.
13 Counsel and Care, Carers UK and Help the Aged (2008) Right care, Right deal Scary, depressing and confusing: Voter’s view of Social Care Revealed.
14 ICM and BBC (2010).
15 Partnership (2010) Over 50s drastically under estimate the cost of long-term care.
Ev w10  Health Committee: Evidence

Other options included more Government information on how to plan for the future, making contributions tax free and special high interest rates. 16

19. By providing more certainty around what individuals must pay to meet the cost of LTC, the new model should, as Dilnot has acknowledged, make it more likely that individuals will seek private sector solutions. Consumers and industry will, however, need to have confidence that any new rules will last if they are to effectively plan ahead.

Some tentative implications

20. The new approach may provide improved incentives for people to consider funding LTC in advance. This could provide more opportunities for financial services to prove its worth in developing solutions to help consumers meet their LTC needs. However, there is still likely to be a worryingly low level of awareness about the costs of care and where to go for advice, increasing the likelihood that people will fail to find funding solutions to meet their prior expectations.

Engaging the public

21. More information and education is needed to raise awareness about LTC. However, this will not be enough to tackle the associated problem of inertia. As the survey results above show, whilst nearly half the population appears to understand that care services are not free, nearly 90% are doing nothing to prepare for the costs. Securing a simple and sustainable funding model as well as raising the level of trust in financial services are important ways to reverse this trend.

22. In a paper published ahead of Dilnot’s final report, 17 we called for a widespread, government-led education campaign to raise awareness about LTC—something which the Commission has also pressed for. We also argued that industry and consumer groups will have important roles to play in informing the public about the options that are available to make the process of paying for care less painful.

23. However, more education and information may not be enough to ensure that consumers are willing to engage with LTC issues including financial products and services. Another crucial barrier to engagement cited in the literature is inertia—many consumers are doing nothing despite the fact they understand some of the potential risks of inaction.

24. In part, inertia is likely to be a function of the regularly changing landscape for retirement. There is a general recognition that people expect the LTC system—as with pensions—to change on a regular basis. People cannot be expected to effectively plan for the future without a stable environment in which to operate, particularly when there are so many other variables, such as the macroeconomic environment which remain uncertain. In this context, the Dilnot report will actually help to fuel uncertainty about near term future costs as people wonder what funding system will ultimately emerge.

25. However, this does not, on its own, explain why the public appears to be reluctant to engage with financial services on the issue of LTC funding. In this context it is worth referring to a recent report by the Social Market Foundation which neatly explains why distrust of financial services may be the most important cause of inertia:

26. “A pervasive sense of distrust among consumers means they are likely to write financial service providers off as ‘all the same’, without even checking what is on offer on the market. Furthermore, behavioural economics suggests that consumers become disengaged in the face of market complexity: they are therefore less likely to check the market if they cannot easily understand or compare products on it.” 18

27. Therefore, in order for the public to view financial services as a key part of the solution, initiatives are required to raise the level of trust and confidence in the industry.

Tackling distrust

28. There is evidence to suggest that practitioners that commit to best practice in terms of qualifications, continuing professional development and a code of ethics benefit from greater levels of public trust. Current initiatives to raise the professional standards of those working in the industry may therefore help to improve levels of public confidence across the board.

29. The Financial Services Authority’s Retail Distribution Review (RDR) is one such project. Its specific objective is to improve public trust in retail financial services by raising the mandatory qualification level for financial advisers and banning commission payments. This enhanced qualification requirement could mean that eventually more practising advisers undertake specialist learning related to LTC. 19 New rules on commission will also ensure that advisers can only receive payment following upfront agreement with the customer on the

19 The CII currently has 5000 members qualified to provide financial advice on long term care.
cost of financial advice. The measures are designed to reassure consumers about the competence of financial advice and the transparency of the distribution process.

**SOLVING A MULTIFACETED PROBLEM**

30. From the above analysis, it is clear that developing a fairer LTC system where the public actively seeks appropriate financial products and advice to help meet their funding needs, requires a multifaceted approach focusing on a number of key, related areas.

*The funding model*

31. The funding model can limit what an individual is required to pay for care and determine the type and size of the risk to be covered by the insurance industry.

*The market for financial products*

32. Stimulating consumer demand for LTC financial products is not just a function of the funding model. A thriving market will only be achieved by substantially raising awareness about care costs and the degree to which consumers are willing to engage with the industry.

*Consumer awareness and engagement*

33. The level of public awareness about care costs is currently so low, and level of public inaction so high, that measures outside of those recommended by Dilnot need to be considered. Improving the durability of LTC policy and the trustworthiness of financial services will be key to tackling these issues.

*The cost of care homes*

34. Whilst the future cost of care homes is outside the scope of this report much depends on it. If the average cost of care homes suddenly increases well beyond £26,000 a year, then government might have to rethink the level of the funding cap and this could have knock on effects for the market for LTC products and the level of consumer awareness and engagement. The diagram opposite sets out the relationships between some key parts of the puzzle.

**Figure 1**

A MULTIFACETED APPROACH TO FUNDING LTC

Cost of residential care

- The cost of residential care impacts upon the required size of the cap and in turn the market for financial products

- Dilnot proposals
- Capping tail-end risk improves consumer understanding and insurability
- Information campaign raises awareness
- Reliance on needs assessment approach reduces potential for prefunded insurance

Consumer engagement

- Efforts to professionalise financial services raises standards of practitioner behaviour and consumer trust

Trust and Confidence

Market for LTC financial products

- Appropriate products and advice

Available for download here: http://www.cii.co.uk/pages/research/researchandsurveys.aspx

**Conclusion**

35. Dilnot’s recommendations are a good start—setting out a fairer approach to the funding of LTC which will, if implemented, help prevent self-funders spending the majority of their assets on paying care home fees.
The proposals would also provide improved incentives for the development of financial products such as immediate needs annuities, and could lead to greater demand for financial advice as the cost of care becomes clearer.

36. However, on its own a new funding model cannot resolve the chronic problems of a lack of consumer awareness and engagement which will, if left unresolved, deter people from adequately protecting their assets through financial services as they grow old. From the CII’s perspective, there are three areas in particular where more effort must be made to reverse these detrimental behavioural trends.

— **Political consensus** on the LTC funding model is crucial. Government and opposition must do their best to provide certainty about future rules—making cross party support for the eventual settlement vital. People cannot be expected to effectively plan for the future without a stable environment in which to operate.

— **Trust** is a key issue and the industry must embrace reforms such as the Retail Distribution Review (RDR) which is aimed at improving levels of public confidence around financial services and products. Those with an interest in raising the level of consumer trust and engagement must therefore do more to improve public awareness about efforts to professionalise financial services.

— **Education and easy access to understandable information is also important.** In this regard, we would reiterate our earlier call for a government–led education campaign and back Dilnot’s proposals in this area.

37. There is general consensus that the current funding system is outdated. Now all interest groups must ensure that the momentum for reform created by Dilnot is sustained, and a new lasting settlement formed, which delivers much improved financial security and peace of mind for our elderly.

*October 2011*

**Written evidence from the British Red Cross (SC 07)**

1. **Key Points**

— We broadly support the recommendations of the Dilnot Commission but believe that there must also be a clear focus on lower level need and preventative services if a sustainable funding solution is to be reached.

— We particularly support the recommendation that work should be undertaken to simplify existing assessment and eligibility frameworks, and to establish national eligibility criteria and portable assessments for social care.

— We are concerned that at a time when integration is increasingly being discussed, the tightening of eligibility criteria across social services is creating a situation where those requiring social care support may only be able to access statutory health care. Rather than delivering integration, this situation leaves a gap in provision for vulnerable people who feel alone and isolated after a healthcare crisis.

— Voluntary sector services such as ours play a key role in bridging that gap and have recognised expertise in integrating service holistically around the service user.

— Maximising this potential requires the VCS to be recognised as valuable commissioning partners—as well as providers—and this should be supported through further specific guidance to health and wellbeing boards to put mechanisms in place to fully engage the sector in their work.

2. **Our Experience**

2.1. The British Red Cross works in the UK and internationally to support people through crisis situations and build their resilience.

2.2. We have over twenty years experience of working in the health and social care sector throughout the UK and provide tailored support services to vulnerable people at times of crisis to address their practical and emotional needs, and enable them to live independently and with dignity in the community.

2.3. In 2010, we supported over 45,500 vulnerable people to regain their independence at home, working through 130 contracts with local authority and NHS commissioners across the UK to deliver flexible support, transport, and short term equipment loan services.

2.4. We deliver a quality assured, time-limited support that enables vulnerable people to recover from crisis by bridging the gap between hospital and the community. We work across age groups and different health conditions to offer a flexible support that can facilitate timely discharge from hospital and prevent readmission through rebuilding service users’ confidence and independence at home. Our service has been recognised by
the Department of Health’s QIPP programme as achieving cost savings of up to £1 million per commissioner per annum.20

2.5. Our response to the consultation is based on this expertise and rooted in our experience of delivering health and care services to vulnerable people.

3. VIEWS ON FUNDING SOCIAL CARE

3.1. The British Red Cross support the recommendations of the Dilnot Commission and believe that the cap system proposed has the potential to support individuals to become more resilient by being able to better plan and prepare for their care needs in old age.

3.2. However, we are not convinced that, as Dilnot has suggested, funding for preventative services will be made available from the ring-fenced Public Health budget, and are concerned that the cap system proposed by the Dilnot Commission would not impact on those whose needs are not deemed to be “substantial”.

3.3. We therefore believe that there must also be a clear focus on lower level need and preventative services if a sustainable funding solution is to be reached, and would highlight Dilnot’s recommendation that there is a clear need to “devote greater resources to the adult social care system”.21

3.4. We would suggest that if Dilnot’s proposal are to be implemented, the Department of Health must invest in making a strong economic case to local authorities that investment in lower level services can deliver significant savings, by preventing service users reaching the cap at which local authority liability for services— which would be both more intensive and expensive—would be triggered. With the current tightening of eligibility criteria for access to Social Services support, this issue is likely to take on greater significance.

3.5. Finally, we particularly support the recommendation that work should be undertaken to simplify existing assessment and eligibility frameworks, and to establish national eligibility criteria and portable assessments for social care. As a humanitarian organisation we believe that this would deliver much greater transparency and equity in social care provision across the country and, once implemented, would provide a much clearer picture of levels of need. We believe that this work should be made a key priority and announced in the forthcoming White Paper on Social Care.

4. VIEWS ON INTEGRATION

4.1. We welcome the Government’s stated commitment to promote integration between health and social care services. However, we are concerned that at a time when integration is increasingly being discussed, the tightening of eligibility criteria across social services is creating a situation where those requiring social care support may only able to access statutory health care. Rather than delivering integration, this situation leaves a gap in provision for vulnerable people who feel alone and isolated after a healthcare crisis.

4.2. Voluntary sector services such as ours play a key role in bridging that gap through our time-limited health and social care offer, which supports those with lower level needs to regain their sense of independence after crisis, for example, an extended period of hospitalisation. Our volunteers also support service users to rebuild their confidence and integrate back into the community, linking them in with services which can meet their needs and building their resilience. This approach not only helps the individuals’ personal needs but also saves the NHS money. For example, a study of one hospital discharge scheme in Wales undertaken by the University of Bangor found that only 3.01% of service users were readmitted in the six months following their discharge, compared with the NHS Trusts’ figures for the same period which showed a 12% readmission rate within 28 days. This report showed that the emotional support provided by the British Red Cross was a fundamental element of the beneficiary experience and a key part of supporting their recovery.22

4.3. Providing this time-limited lower level support means we are also able to advocate on behalf of those who need to access support from social services and bridge professional boundaries between health and social care. This promotes a whole systems approach to integrated services around the individual, preventing a series of isolated incidents of care. A service-user case study highlighting this work is at Appendix 1.

4.4. In addition to promoting a better experience of care, the role the voluntary sector can play in supporting better integration of services also delivers efficiency savings. For example, our Nottingham Crisis Intervention Community Support Service, offers an intensive support service for those referred from their GPs and aims to stop preventable hospital admissions. The service has been estimated to save GP practices an average of one hour per referral, and avoid hospital admission in every 2.4 referrals.

20 Department of Health Quality Improvement and Productivity Programme (QIPP), www.evidence.nhs.uk/quality and productivity
21 Fairer Care Funding (2011) The Commission on Funding of Care and Support, p 7.
22 Dr F Zinovieff & Dr C Robinson, The Role of the Voluntary Sector in Delayed Transfer of Care (DTOC)/ Hospital Discharge and Prevention of readmission, Bangor University, October 2009.
4.5. Maximising this potential requires the VCS to be recognised as valuable commissioning partners—as well as providers—and this should be supported through further specific guidance to health and wellbeing boards to put mechanisms in place to fully engage the sector in their work.

October 2011

APPENDIX 1

SERVICE USER CASE STUDY: FROM OUR LEICESTER SERVICE

Ms Ahmed is 82. She has a history of falls and confusion and was referred to our service by hospital ward staff after suffering another fall. Ms Ahmed said that she was managing well at home with support from her daughter, but hospital staff were concerned that they were both finding it difficult to cope.

When our support worker visited Ms Ahmed at home, they found that she was sleeping on the sofa and neglecting her personal care. The fridge was stocked with out of date food, the house was dangerously cluttered and there was a high risk that Ms Ahmed would fall again. Our worker threw away out of date food, removed trip hazards, cleared space for Ms Ahmed to move about safely and discussed concerns with Ms Ahmed’s daughter who admitted that she was unable to cope but didn’t know where to turn for help.

We contacted social services to request an assessment as soon as possible, and referred Ms Ahmed to the Falls Prevention team who provided intermediate care. Our support worker also advised Ms Ahmed that she would be eligible to claim for Attendance Allowance to help pay for the help she needed and supported her to complete the appropriate paperwork.

Together with the intermediate care team we were able to persuade Ms Ahmed to accept some help with personal care and to clear her house to relieve the pressure on her daughter. Ms Ahmed has now accepted that she needs more help and Social Services have arranged for her to have a carer three times a day.

By providing practical and emotional support to Ms Ahmed and her daughter we were able to gain their trust and support them in identifying their needs. We were then able to make a series of referrals to other agencies, and continued to provide support until appropriate longer-term care was in place.

Our support meant that Ms Ahmed and her daughter were able access the assistance they needed, and as a result Ms Ahmed was able to remain safely in her own home.

Written evidence from the National Institute for Health and Clinical Excellence (NICE) (SC 08)

SUMMARY
— This memorandum is about the role of NICE in supporting the integration of health and social care services.
— Several items of NICE guidance already make recommendations aimed at social care. Also, NICE guidance on various long-term medical conditions is relevant for social care commissioners.
— The Health and Social Care Bill gives a re-constituted NICE formal responsibility for providing social care Quality Standards and guidance from April 2013. This will enhance NICE’s ability to promote service integration. The social care sector has generally welcomed this extension of NICE’s functions.
— The role of NICE Quality Standards for the NHS is well defined but that of social care Quality Standards much less so. This is largely because there are considerable differences between the NHS and social care in the structure, nature and financial basis of services, accountability arrangements, and professional cultures.
— NICE is working closely with the social care sector to develop the methodology and processes for producing social care Quality Standards.

ABOUT NICE
1. The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance, including Quality Standards, on the promotion of good health and the prevention and treatment of ill health. We also provide other evidence-based services, particularly NHS Evidence, a web portal for evidence on health and social care, and information about medicines through the National Prescribing Centre.

INTRODUCTION
2. Many of the issues to be considered by the Committee’s inquiry fall outside NICE’s remit. This memorandum therefore focuses on the practical and policy implications of the government’s stated commitment to promote integration between health and social care services. In doing so, it also touches on certain implications of the government’s commitment to promote personalisation of social care, including personal budgets and direct payments.
Promoting Integration of Health and Social Care: NICE’s Role

3. In white papers and other policy statements and consultations the government makes the case for integration wherever appropriate of health, social care, public health and other local services. Practical measures for supporting integration are emerging and more will fall into place over the next few years. They include:

- interrelated outcomes frameworks for the NHS, social care and public health;
- local health and wellbeing boards with duties of partnership in coordinating and integrating health and social care services and public health;
- local collaborative commissioning and performance management arrangements centred on joint strategic needs assessment and health and wellbeing strategies;
- the application across the sectors of common principles, such as personalisation, partnership, plurality of provider, prevention, and efficiency; and
- the development of common approaches across the sectors to defining and improving the quality of services.

4. NICE’s particular contribution is in encouraging the uptake of evidence-based guidance to improve service quality and achieve better value for money. Our current formal remit is to provide guidance on healthcare and public health. However, where guidance topics call for a broader range of interventions, our recommendations cover the whole care pathway, including the contribution of social care, and not just the part of the pathway concerned with clinical care.

5. The most substantial examples are NICE’s clinical guideline on dementia—produced with the Social Care Institute for Excellence (SCIE)—and the subsequent dementia Quality Standard. We also worked with SCIE on a clinical guideline on pregnancy and complex social factors and on public health guidance on promoting the quality of life of looked-after children and young people.

6. Other examples of NICE guidance that explicitly cross the boundaries of service sectors are our clinical guidelines on the assessment and prevention of falls, hip fracture, and autism spectrum disorders in children and young people, and public health guidance on mental wellbeing and older people. In addition, much NICE guidance is about the treatment and care of people with long-term medical conditions and so should inform joint commissioning of services for the substantial number of people with long-term conditions who also need social care support.

7. We have welcomed provisions in the Health and Social Care Bill giving a re-constituted NICE formal responsibility for providing social care Quality Standards and guidance from April 2013. In general, the social care sector is as positive as we are about NICE’s involvement and we are working with it in a range of activities to pilot methods and a process for developing these products.

8. This extended remit will enable us to design Quality Standards that encourage necessary connections along care pathways between clinical care, disease prevention in NHS settings, social care, and broader public health interventions, thus increasing the potential to achieve outcomes shared by the sectors as well as each sector’s priority outcomes.

9. The role of Quality Standards in improving the quality of NHS services is quite well defined: the intention is that they will underpin the commissioning process and give focus to the improvements in service quality necessary for progress in the domains of the NHS outcomes framework. In particular, the indicator measures developed for Quality Standards will form part of the commissioning outcomes framework and will thus be used by the proposed clinical commissioning groups to assess their progress on local health priorities. So far, we have produced 12 Quality Standards and we aim to produce 150 by 2015.

10. The thinking about the role of Quality Standards in social care is less developed, largely because account must be taken of the considerable differences between the sectors in the structure, nature and financial basis of services, accountability arrangements, and professional cultures. For example:

- Social care is a responsibility of democratically accountable local councils rather than the local arm of a national organisation, so the process for achieving implementation of guidance on good practice is even less straightforward than in the NHS.
- Social care meets a diverse range of needs through an array of publicly and privately funded services, which are predominantly provided by the private and voluntary sectors, and mainly through small enterprises. This is an implementation challenge but also points to the importance of engagement with the sector.
- Personalisation in the form of personal budgets means that growing numbers of people are commissioning their own care and support. In addition, there is substantial co-payment by users, and many users pay for care without any involvement of the local authority. There are therefore many perspectives—demonstrated by care users’ practically expressed preferences—on what constitutes quality and value for money, in contrast with the single-payer perspective in the case of NHS services.
— There have been minimum standards and now registration standards for social care provider agencies but no commonly accepted definitions of what quality consists of in general nor in relation to specific services. The Department of Health has stimulated debate about the definition of quality in adult social care, and SCIE has proposed a definition of excellence in adult social care. Social care Quality Standards and NICE social care guidance would complement a general definition with specific descriptions of service quality.

— The concept of evidence-based social care is much less developed than that of evidence-based medicine, as is the research infrastructure, underlining the importance of careful piloting of Quality Standards.

— The social care workforce, particularly in its lower tiers, is less well trained than the NHS workforce and has fewer opportunities for professional development. This is an obstacle to the dissemination and uptake of good practice.

11. These differences have implications for the integration of health and social care services in general and not just for the task of producing social care Quality Standards and guidance. By working closely with the social care sector, we believe we can resolve practical problems arising from them and begin to introduce social care some of the rigour of the evidence-based approach NICE has brought to clinical care and public health.

October 2011

Written evidence from the Joseph Rowntree Foundation (SC 10)

The Joseph Rowntree Foundation (JRF) is one of the largest social policy research and development charities in the UK. JRF’s purpose is to search, demonstrate and influence, providing evidence, solutions and ideas that will help to overcome the causes of poverty, disadvantage and social evil. JRF has a long history of researching the needs and aspirations of older and disabled people, and how these can be met. We also have practice experience through the Joseph Rowntree Housing Trust—a provider of housing and care services in Yorkshire and Hartlepool.

Funding Social Care and the Dilnot Commission Recommendations

1. JRF believes the Dilnot Commission recommendations represent the best chance yet to create a fair, transparent, sustainable (financially and socially) funding settlement for adult social care. The current system of social care eligibility and its funding is opaque and confusing, and multiple funding streams create confusing and even irrational, overlapping ways of paying for care (Hirsch, 2006; Beresford 2010).

2. JRF considers the priority next steps for this government to act on the following recommendations from the Dilnot Commission:

2.1. Retaining a safety net for older and disabled people in poverty.

2.2. Raising the current threshold to £100,000.

2.3. Universal entitlements to information, advice, assistance and advocacy.

2.4. A national framework for eligibility and assessment of individuals for adult social services, with portability of assessments, charging arrangements, carers’ assessments and expectations that assessments are co-produced with individuals who need support.

2.5. Presenting clearly how much individuals are expected to contribute to the costs of their own care, and when and how they make this contribution, what they will get in return and what the state will provide.

3. There are three areas that we believe the Dilnot Commission recommendations did not address adequately: prevention; housing; and a funding system that supports the outcomes people value.

Prevention

4. A reformed social care system must support and incentivise more investment in what older people have described as “that bit of help” (CPA 2011). In the words of Nell McFadden (a member of the JRF Older People’s Inquiry from 2005–06):

“Looking at the big picture we need support or services to help us to live an ordinary life. We need good housing; accessible, affordable transport; help for all the wee jobs at home which many of us are unable to do as we get older. It is no use having to sit at home and look around you and see jobs needing done which at one time you were able to do but now have no-one to do for you. Can you imagine how frustrated and depressed that can make you feel? Many need someone to go with them for shopping, doctor’s appointments and other outside engagements and (unless there is a service in


their own area to cover) that means that many older people would be stranded at home and become lost to society. Even in our own homes a few aids and adaptations can raise quality of life, our expectations and comfort levels. One cannot underestimate the difference to older people’s quality of life that little bit of help makes. That bit of help and support that I need to contribute to the community and society means so much to me. I have been given back my independence and it has raised my quality of life and well-being’. (Nell McFadden 2010, cited in CPA 2011)

5. “That bit of help” is how older people who were part of the JRF Older People’s Inquiry described low-level, highly-valued support that enables people to live well in their own homes, often bringing savings to the public purse through reducing or delaying the need for more costly services (such as hospital admissions or residential care).

"Older people really valued practical support that enabled them to live well in their own homes. This covered help with cleaning, payment of bills, DIY, gardening, care of pets, chiropody, transport, small adaptations, befriending and opportunities for social participation (Godfrey et al. 2004; Raynes et al. 2006; Clough et al., 2007). The positive benefits went beyond cost-effective delivery for people who were eligible for support, reaching out to individuals and into wider communities, building social capital”. (CPA 2011)

6. JRF believes that the Dilnot recommendations are not sufficiently robust on how a reformed funding system might incentivise investment into low-level support—whether that investment is made by individuals, communities, the NHS, local authorities or other agencies who should be incentivised (through funding and legislation). Reductions in local authority budgets, increasing demand and changes in some welfare benefits (such as Disability Living Allowance) may jeopardise funding for exactly these sorts of valuable services (Smith and Cavill 2010), despite clear evidence of its value to older people and cost-effectiveness (CPA 2011).

**Housing—Not Just Health and Social Care**

7. The government’s commitment to improve integration between health and care is crucial and to be welcomed. But more consideration needs to be given to the integration of these services with housing. Health, social care and housing are three points of a triangle of support for older people and younger disabled people alike:

“Older people with high support needs live in a range of settings including: residential or nursing care homes, sheltered housing and housing with care schemes, and in their own or relatives’ homes, where many live in substandard private sector housing and an increasing number live alone. Older people with high support needs, their supporters and those working with them face a number of challenges in each of these settings. These include: affordability; navigating the system; dementia and mental capacity; social isolation; recruiting and retaining a skilled workforce; involving and supporting carers; end-of-life care. Accessible, secure and conveniently-located housing options are essential if independent living and informal networks are to flourish for older people with high support needs. Ensuring Lifetime Homes standards are applied in new developments would be a key step towards “future-proofing”. Developing and evaluating the role that retirement villages and other forms of housing with care can play in providing a “home for life” for those with high support needs is also a clear priority”. (Blood 2010)

8. Services which are poorly integrated with a person’s housing may lead to a premature loss of independence and move to residential care.

9. Several “middle way” options now exist between residential care and domiciliary care, including extra care housing, supported living for younger adults, co-habitation and innovations such as “shared lives” (Bowers 2011; Burke 2010; Manthorp, 2010). These schemes look promising in promoting independence, quality of life and social well-being for those who cannot live wholly unsupported, but whose needs are not complex enough to require residential care (Callaghan et al 2009; Bäumker et al 2008), and potentially those with complex needs (Bowers et al 2011).

10. Promising options can also be very complex. For example, “housing with care” covers a very wide range of settings and schemes, varying widely by type of provider, size and scale, location, services and cost. Early findings from JRF research by the Housing and Support Partnership has identified several areas where roles and responsibilities are contested, including around decisions to move in and allocations; buildings and facilities provision, management and maintenance; health and safety; promoting well-being; safeguarding and duty of care; managing increasing care and support needs; whether housing with care offers “a home for life” (Pannell and Blood 2011). This paper is a timely reminder of both complexities, and the importance of housing when shaping the future direction of health and social care for older people and disabled people.

11. The Dilnot Commission did not explore housing options in depth, however, the White Paper must think ahead—particularly in the light of recent events—to a time where demand for more flexible housing with care options is much greater. The forthcoming White Paper and any future social care statute and funding system must recognise the role appropriate housing plays in meeting people’s outcomes and quality of life.
OUTCOMES THAT OLDER PEOPLE WANT AND VALUE

12. Older and disabled people, when asked to describe what they value and want from life, seldom talk in terms of service areas. They talk about broad outcomes, such as maintaining and developing friendships and social relationships, having a meaningful community life, and personal identity and self-esteem (Stone and Wood 2010; Bowers et al 2009; Katz et al 2011 forthcoming). These span a range of service areas—health, social care, housing; also transport, leisure, welfare benefits and rights. The lack of integration between budgets, eligibility, operational cultures, standards, regulatory frameworks and processes often gets in the way of achieving the outcomes people value.

13. Research for JRF by a team at the Open University reviewed existing evidence about what older people and/or people with high support needs value in their lives, and verified the themes through fieldwork with 26 (mostly older) people with high support needs, diverse in terms of their gender, ethnicity, geographical location and type of disability or health condition, and who had not previously been consulted. Everyone had different values and preferences, but all expressed some common human needs for social, psychological and physical well-being:

“People valued their close emotional relationships, though some expressed concerns about ‘imposing’ on family and friends.

Having control over their lives meant different things to different people. Adjusting well to change was also central to psychological well-being, and this might require support.

Participants valued getting out and about, keeping mentally and physically active and having contact with nature.

Care, support and other people’s time were key factors that enabled or prevented people doing things that mattered to them.

Participants faced various challenges and difficulties, some a result of illness, disability and ageing but many because of lack of access to information, money, technology, equipment and transport”.

(Katz et al 2011, forthcoming).

14. The outcomes people value and want to achieve in life need to be at the heart of reforming adult social care (Stone and Wood 2010). These outcomes inevitably imply multiple services working together, and often include “that bit of help” to assist people to live well in their own homes and communities. In preparing the White Paper, JRF would encourage the government to set outcomes that reflect what people value, and encourage joint-working across all sectors (not only health and social care) in order to achieve these.

LEGISLATING FOR SOCIAL CARE AND THE LAW COMMISSION RECOMMENDATIONS

15. The complexity of the care system causes frustration and distress for many people. The Law Commission’s proposed single statute for social care with a set of defining principles and rights, definitions and processes, and a single code of practice, is of vital importance. So too is the proposed general duty on local authorities to provide a universal entitlement to information, advice and assistance—we would add advocacy to this list—if people are to make the most of their own resources and make informed, effective decisions when they need more intensive support, including at times of crisis. However, JRF would hope that future legislation (and the White Paper) addresses the following points more fully:

16. First, more explicit reference to the views and preferences of service users actively setting the agenda for social care and support locally and nationally, for example in commissioning local services (ie beyond self-directed individual care packages).

17. Secondly, explicit reference to Human and Civil Rights, reaffirming the attainment and protection of human and civil rights within the context of adult social care as the founding principle on which this new statute is based (whilst recognising that the statute need not duplicate the provisions of existing legislation).

18. Finally, and in spite of the Commission’s endeavour to create a more person-centred approach to care and to focus on needs and outcomes rather than services, there remain several points in the Law Commission’s report where a service-based approach remains. For example: establishing a prescribed list of services to be used in the definition of community care, alongside a list of outcomes. What are the practice implications of this where (for example) a person’s outcomes can be achieved in ways that are not on the prescribed list of community care services? This has implications for care funding and commissioning.

19. Related to this last point, and the importance of adult social care legislation focusing on needs and outcomes rather than the current menu of services, it is worth noting the interim findings from JRF research underway by the National Development Team for Inclusion and Community Catalysts on alternative approaches to support for older people who have high support needs—specifically, approaches based on mutuality and reciprocity. The team reports:

“There is a great deal of interest from older people and their families about the concept of mutual support, and enthusiasm for finding out more about how to make it happen for individuals and local communities. Amongst professionals and professional bodies, however, there is some hesitation and scepticism about the extent to which such models and approaches are suitable, affordable and practical to achieve for older people with very high support needs”.

(Bowers et al 2011)
PERSONALISATION OF SOCIAL CARE

20. JRF supports the government’s commitment to greater personalisation in social care. Our ageing population is becoming more diverse—both demographically and in the type of support they want—and requires more specialist care as people live longer with multiple needs (Blood et al 2010; Blood and Bamford 2010; Falkingham et al 2010). Changing diversity and changing expectations require person-centred approaches to support, tailored around individuals and their relationships.

21. However, our research highlights that personalisation is about far more than promoting personal budgets and direct payments. The Standards We Expect consortium recently published findings from a major study involving service users, carers, frontline care workers and care managers on transforming and sustaining person-centred support (Beresford et al 2011). This study found strong agreement and support across services users and practitioners about person-centred support. It also found that:

“Much mainstream discussion about personalisation has focused on methods and techniques rather than the objectives of achieving person-centred outcomes. It has been tied to the structures and constraints associated with traditional policy and provision limiting its effectiveness and reducing support for it.
Practitioners and service users are working hard to advance person-centred support in many settings, developing bottom-up ways of challenging barriers. However, there is evidence that a range of substantial barriers is seriously impeding the long-term sustainability and widespread application of person-centred support and putting it at risk.
The inadequate funding of social care and negative aspects of its culture underlie these barriers. These encourage institutionalisation, poor quality provision, inequity and late intervention. As a result people’s basic rights are often not being met. Achieving person-centred support emerges as inseparable from fundamental cultural and funding change”. (Beresford et al 2011).

22. Research on commissioning social care services has shown that the involvement of service users in shaping and commissioning services is at an early stage (Mauger et al 2010). A study involving seven diverse service user groups and commissioners in six areas of London (including older people) found:

“Commissioners and their partners were frequently poorly placed to engage with user involvement in commissioning. Their skills, knowledge and practice of effective involvement were often limited. Even where they had knowledge, there were few drivers which pointed them towards service users and away from simply responding to organisational necessities. […] There seemed to be two ideas within the same system. Individual service users were to have choice and control in line with Personalisation. Commissioners retained control over block contracts. It was difficult to see how one influenced the other”. (Mauger 2010)

23. Personalisation also challenges perceptions of risk, and our approach to risk and regulation must develop in line with the personalisation agenda to recognise the importance of positive risk and risk management, rather than risk avoidance (Glasby 2011; Berry 2011).

CONCLUSION

24. There is an urgent need to reform care funding as without a financially sustainable social care system, other important reforms—such as personalisation, quality and provision of “that bit of help”—cannot be achieved.

25. JRF calls on this government to grasp the nettle of funding reform and capitalise on the broad consensus that has developed across the social care sector in recent years. The Dilnot Commission recommendations, the Law Commission report and the Coalition Government’s Vision for adult social care together present a unique opportunity for comprehensive reform of adult social care. We look forward to a White Paper that implements the key recommendations from these and the further engagement now underway, and that drives forward reform of a system that will be fit for the 21st century.

October 2011

Written evidence from The Henry Spink Foundation (SC 12)

SUMMARY
1. Background to the Henry Spink Foundation.
3. Response to question on barriers faced by recipients of social care when they wish to relocate.
4. Response to question on the practical and policy implication of the commitment to promote integration between health and social care services.

1. The Henry Spink Foundation, an independent charity, was created by Michael and Henrietta Spink, who are campaigners for the disabled. Based on our personal experience and that of others who have turned to our Foundation for help, we have campaigned for three easy, cost effective policy changes: to reform local authority
3.1 The portability of care services can be defined as the right of a person to take an assessment and the support package which forms the outcome of that assessment from one local authority area or local health administrative area to another (“the receiving authority”), when the person receiving services becomes ordinarily resident within the receiving authority or is being provided with services by the receiving authority.

3.2 The Henry Spink Foundation strongly supports the principle of portability of care services and carers assessments (for children and adults). There have been several attempts in Parliament to introduce portability, most recently in the Personal Care at Home Act, 2010. (Draft Personal Care at Home (England) Directions 2010), and the Social Care Portability Private Members Bill introduced recently in the House of Lords.

3.3 We believe that a simple framework for portability should be created, allowing for the transfer of care packages, both domiciliary and residential, from one authority to another, as well as carers assessments and support. The receiving authority should have the right to carry out a new assessment if it wishes, within a specified time frame, with any significant amendments to the previous assessment and support package being clearly explained in writing. This allows for local outcomes to support packages resulting from assessment.

3.4 Although the need for capital expenditure under the Disability Facilities Grant would be included in such an assessment, it should be recognised that this is not an irreconcilable impediment to portability and can be treated as an issue consequent on transfer of a care package.

3.5 The introduction of national eligibility criteria would help in the transfer of care packages from one authority to another, but is not immediately essential. Social workers responsible for assessments are trained to a national level already, with qualifications gained before they are employed by local authorities. A de facto national standard applies to assessments already, which is subject to judicial review. A receiving authority should have no difficulty in accepting an assessment properly prepared by another authority.

3.6 Introduction of portability would save money and time in hard pressed social service departments. Assessment and care management, which includes the process of receiving referrals and assessing need, cost £2 billion in 2008–09. (Personal Social Services Expenditure and Unit Costs England 2008–09, table 2.3 (Gross Current PSS Expenditure by type of provision, 2008–90) The Health and Social Care Information Centre 2010). If only 10% of these assessments represent re-assessment due to relocation, this could largely be saved through enabling our portability proposals, representing some £200 million per annum.

3.7 The introduction of portability would mitigate future costs of care by optimising family support, job opportunities and access to suitable housing for those needing care and support. This is relevant to the Call for Evidence as we are proposing a small but significant change in the basis of the funding stream an individual receives which would result in significant efficiency savings. Our proposal retains local responsiveness to
assessed need, while allowing access to services nationally during the interim period between moving home and being re-assessed by the receiving authority.

3.8 Our proposals for portability should be considered to be at least cost-neutral, and will create savings in the costs of assessments.

3.9 The establishment of portability does not need to wait until a root-and-branch overhaul of adult social care has taken place, and should be introduced as quickly as possible.

4. The practical and policy implications of the Government’s stated commitment to promote integration between health and social care services

4.1 There is significant overlap in the commissioning and provision of services by social care services and health services. This point is also noted in the Dilnot Report (p 16).

4.2 From the perspective of services users, it is often almost impossible to distinguish who is actually responsible for provision of services. This must be clarified by giving service users a written list of contacts and their specific responsibilities. The problem is especially acute in cases where funding is split between Health and Social Care.

4.3 Lack of co-ordination in the commissioning of services is leading to an inefficient use of resources, particularly with regard to failure to forward plan emergency provision causing overcharging in some cases by care agencies.

4.4 Assessments should be unified so that there is no need to repeat assessments carried out by social care services if there is a transfer into continuing healthcare and vice versa.

October 2011

Written evidence from Dr Keith Robinson (SC 13)

SUMMARY

This note is concerned with “the practical and policy implications of the Government’s stated commitment to promote integration between health and social care services”. It identifies five broad obstacles to integration and suggests how they can be overcome. These obstacles are:

— Professional differences in practice and culture.
— Conflicting priorities.
— Different lines of accountability.
— Budget boundaries.
— Short term rather than long term thinking.

The note concludes by suggesting that the Committee may wish to invite the Secretary of State to require the relevant local Health and Council bodies to prepare joint organisational development plans showing how they would propose to tackle those issues, in order to make a reality the goal of integrated and timely services which meet people’s individual needs and preferences.

1. This note focuses upon the final issue of those listed in the Committee’s call for evidence, namely:

The practical and policy implications of the Government’s stated commitment to promote integration between health and social care services.

2. The arguments for integrated health and social care are so familiar, so widely understood, and indeed so evident, that the Select Committee should ask itself not “is integrated care a good thing?” but “why is integrated care not yet in place?”, and more particularly, “what are the obstacles to its introduction?”.

3. The search for an answer will take the Committee into questions about the machinery of government and (although this may sound like an oxymoron) the dynamics of bureaucracies. For the way in which organisations work can undermine the aspirations of “front line” professional workers, and the policies of government Ministers.

4. As Chief Education Officer and then as Chief Executive of a large, latterly unitary, Council I spent 14 years working with colleagues from other public and voluntary organisations to provide integrated and timely services which met people’s individual needs and preferences. The overriding obstacle which we encountered was not obstructive individuals or lack of resources but the difficulty of aligning different organisations so that their individual interests, priorities and ways of working matched our collective ambitions.
5. The obstacles to integration include the following.

(i) **Professional differences in practice and culture**

6. Integration will not work unless all the professionals concerned share an understanding of the overall goal and how they and others contribute to that. The goal of integrated services runs counter to the prevailing focus on individual services—discrete, separately funded, staffed by distinctive professional groups, and managed by different organisations. Without abandoning the concept altogether, we must recognise that individual services are subordinate to the higher goal, of providing an integrated range of services which support the individual and enable him/her to achieve the best possible life.

7. Different professions usually have their own methods of assessing patients/clients, who are endlessly assessed when they should be receiving help. A single joint assessment is required.

8. The typical relationship of a health professional with a “patient” is different from that of a social worker with a “client”. To put it crudely, the relationship of power is different. Notions of “empowerment” will differ accordingly. A single shared vision of “the client/patient” is required.

(ii) **Conflicting priorities**

9. Integration is possible only if all parties agree upon the desired result and upon its relative importance. It must be pursued in a sustained and consistent way.

10. The simplest way of establishing a common priority for integration across all the relevant services might be to bring them together in one organisation, responsible for Health and Social Care in each locality. That seems to me to be impracticable at present. An alternative would be to establish a body which comprised the relevant local organisations and whose decisions were binding upon those organisations. Public sector partnerships are all very well but they should have compelling authority; it’s too easy for their members to sign up to common goals without putting those goals at the heart of their organisations. The local Health & Well Being Boards seem to me to lack the teeth to ensure that the organisations in membership change their behaviour and policies to reflect common aims.

(iii) **Different lines of accountability and influence**

11. The likelihood of conflicting priorities is increased when organisations have different lines of accountability, to different masters. Primary Care Trusts have tended to act in accordance with the directions of their Strategic Health Authorities, which have often placed narrow health priorities above broader integrated objectives. Although Councils are not accountable to the Care Quality Commission and its predecessors, they have been heavily influenced by the CQC’s standards and performance measures. It is not clear to me who the proposed clinical commissioning groups will be accountable (and it is not enough to say, “accountable to the patient” unless that can be reflected in effective procedures for holding them to account). Integration will be easier if the relevant organisations are individually and collectively accountable for that goal to a single overarching local body. The CQC also has a role.

(iv) **Budget boundaries**

12. Integrated services will save money, but not necessarily overnight for every organisation. Some early investment will be required (eg in new procedures); and savings will not necessarily fall where costs lie (eg action to reduce “bed blocking” saves NHS funding but will cost the Council, at least in the short term).

13. Particularly at a time when budgets are under severe pressure, organisations will tend to protect their own budgets rather than investing in wider initiatives where the boundaries of responsibility may be unclear. Managers will typically be concerned above all with budgetary control, taking a cautious attitude towards any commitment which puts that at risk. This attitude is perfectly rational from the viewpoint of the individual manager yet is fatal to the goal of integrated services.

14. When a large organisation is threatened by reductions in resources, different parts of the organisation will fight their corner and it will become harder to take decisions which reflect the objectives of the overall organisation. The ultimate purpose of the organisation may be lost from view as people focus on internal issues—viewing the organisation as an end in itself. External relations are likely to be subordinated to internal considerations—this is why the third (voluntary) sector is currently at risk, despite its crucial role in adult care and other services. People taking decisions in organisation will be tempted to take the options which suit their interests—eg cutting contracts with third parties is easier than the trauma of internal redundancies, yet those external contracts may be more important to the objectives of the organisation.

15. All these characteristics must be recognised and confronted by the organisations’ leaders in order to introduce integrated services in the current financial climate.
(v) Short term rather than long term thinking

16. Many factors contribute to a climate of short term thinking in our public services, including annual budgeting, reorganisation and uncertainty, and short term (typically, process-based) targets. The development of integrated and timely services which meet people's individual needs and preferences will be a long journey, requiring sustained and determined leadership; such leadership is undermined by these short term factors.

17. Organisations should be able to plan their budgets over the medium term, and should be encouraged jointly to commit resources within those budgets to the goal of integrated services. They should be encouraged to assess their effectiveness by reference to measures relating to integrated care and to the effects, in terms of quality of life and satisfaction, which it is intended to bring.

HOW TO OVERCOME THESE OBSTACLES

18. Various measures should be taken to overcome these obstacles:

- The relevant professional associations (including the GPs') should be tasked to design within six months a single common assessment framework for health and social care.
- The relevant public bodies locally should be tasked to adopt a joint statement of "customer care" (for want of a better term) which describes the ideal relationship between professional workers and the patient/client. A model statement should be prepared by the professional associations with appropriate user and consumer groups (e.g. Age UK and the Alzheimer's Society).
- If integrated and timely services which meet people's individual needs and preferences really are the priority in Health and Social Care (as I believe they should be) Government Ministers and the leaders of the relevant organisations must reflect that in what they say and do. In my view the proposed Health & Wellbeing Boards lack sufficient authority to act decisively to drive local authorities and commissioning boards towards this goal. They should be given the powers to require their constituent organisations to act in accordance with the goals which they jointly adopt. (This may have implications for the balance of their membership).
- Everyone working in the relevant organisations must understand that the goal of integrated services is of paramount importance to their organisation, and why. Formal and informal reward systems (e.g. appraisals, promotions), must reflect this.
- Integrated services require integrated budgets with simple lines of accountability. The organising concept for those budgets should not be, as at present, individual services but a dynamic programme of support for the individual which reflects his/her needs and preferences and also is changed to reflect changes in those needs. As the nature of the care changes, the respective financial contributions of the organisations can be reviewed according to the single common assessment framework; alternatively, in the longer term, a single Health & Well Being Board (or its successor) can take responsibility for funding throughout the process. Furthermore, this funding should be planned on a three-year rolling programme to which all the parties commit themselves.

19. It is not enough for Ministers, and Councillors, and Health leaders, to support the goal of integrated services, they must make radical changes to the way in which their organisations work in order to make integrated services possible. Integrated services require integrated management and some degree of joint responsibility and authority.

20. The key issue is the relationship between public services and the people they exist to serve. We all pay lip service to the notion that the patient/client’s wishes and needs are paramount, but the structures and procedures within which we work undermine this noble goal. Personal budgets will help, but will not by themselves bring about the changes in organisational thinking and practice which are required. For some people, facing the anxiety and uncertainty which can be associated with serious illness or old age, the choice which comes with a Personal Budget may create stress rather than satisfaction; and Personal Budgets by themselves will not overcome the various obstacles to integration which are identified in this note.

21. The proper relationship between public services and the people they are intended to help cannot be reduced to that of a cash transaction. It is more complex than that. Professional workers need the time to understand a person’s situation and how he/she feels about it; what future life he wants for himself, and what he fears may prevent that. This relationship goes well beyond that of providing a range of different services: c.f. the promising work which has been undertaken in Swindon and elsewhere, with families with complex

25 There is evidence (e.g. in work which Charteris has done with Wiltshire Council) that "packages" of care are not reviewed and changed sufficiently quickly, with the result that people are kept in a condition of dependency when they should be helped to achieve greater independence (e.g. short term residential care is extended until people become dependent upon it).

26 "There is no denying that choice improves the quality of our lives... Choice is essential to autonomy, which is absolutely fundamental to well-being... On the other hand, the fact that some choice is good doesn’t necessarily mean that more choice is better... Clinging tenaciously to all the choices available to us contributes to bad decisions, to anxiety, stress, and dissatisfaction". Barry Schwartz, “The Paradox of Choice,” HarperCollins 2004, page 3.
Political and administrative structures are critical in achieving this change, as they enable the coordination and alignment of resources, policies, and services. The report notes that the current system is fragmented and lacks a cohesive approach to addressing the needs of patients and families. It highlights the importance of integrated care and support, which can help to overcome these challenges and improve outcomes for patients.

The Committee recommends the government to consider extending Monitor’s role to include social care, which would support the integration of health and social care services. This would enable the regulator to ensure that services are delivered in a way that is consistent with patients’ needs and preferences. The government should also consider how the current funding model for social care can be restructured to better reflect the needs of patients and their families.

The report also notes that there is a need for further research and evaluation of the impact of integrated care services. This would help to inform policy decisions and ensure that resources are allocated in a way that maximizes the benefits for patients.

Conclusion

The Committee concludes that the integration of health and social care is a critical issue that requires urgent and coordinated action. The government should work towards creating a system that is more responsive to the needs of patients and their families, and that promotes the delivery of high-quality care.

Written evidence from Monitor (SC 14)

1.0 INTRODUCTION

1.1 Monitor welcomes the Health Select Committee’s inquiry into social care and looks forward to the publication of the Government’s White Paper on social care later this year.

1.2 This written memorandum addresses the proposals in the Health and Social Care Bill currently passing through Parliament, and the possible new role for Monitor in relation to social care.

1.3 This submission does not address all of the elements of Monitor’s current or proposed new role.

2.0 THE INTEGRATION OF HEALTH AND SOCIAL CARE

2.1 While formal evidence in this area is as yet underdeveloped, there is general agreement that the closer integration of health and social care could lead to a better quality of life and their independence. Thus the integration of services must have at its heart the needs and preferences of the people it is intended to help.

2.2 Better integration between health and social care is especially relevant when considering the needs of patients with disabilities, mental health issues, and long-term care. It is equally important for those using specialist services—such as cancer care.

2.3 Integration of health and social care is also important when considering the needs of those receiving specialist services—such as cancer care.

2.4 The Health and Social Care Bill sets out that Monitor will be required to support the delivery of integrated healthcare services for patients, where this would improve quality of care or improve efficiency. While it would be for commissioners, working with local providers, to develop and fund better and more integrated patterns of care, Monitor’s role would be to support commissioners and others, removing any barriers to the integration of services and considering what we could do to promote integrated care provision where this is in the interests of patients. The Bill also provides a mechanism for Monitor’s remit to be extended to social care although the Government is yet to set out when, or if, it plans to enable these provisions.

2.5 Monitor understands that this mechanism has been put in place due to the inter-dependency of health and social care and the importance of improving joint working across health and social care.

2.6 Monitor’s core duty, according to the Bill, would be to protect and promote patients’ interests. We are to do this by promoting the provision of care that is economic, efficient, and effective, and also by ensuring that quality is maintained and, where possible, improved. This would be the starting point for all that we do.

27 “If we look more closely at the way current government activity works, we can see that the way “the system” has evolved now has frontline workers spending the majority of their time on the system itself, rather than in building the kind of relationships that open people to change and address causes rather than symptoms... What’s needed is a new relationship between local government and residents that starts from a different place and supports transformation... unlocking the capability for families to build and sustain the lives they want to lead through a number of enablers: the ability to value yourself and to become aware of what holds you back; a sense of agency and possibility that will allow you to create the life you want to lead; the ability to develop meaningful relationships and build new connections within your community”: http://www.participle.net/projects/view/3/102/ 28 cf the recent report by the Public Administration Committee, which highlights two “critical factors for success in Civil Service reform initiatives and wider corporate change programmes: coordination from the centre and strong political leadership”. The Committee recommends that “… the Government should produce a comprehensive change programme articulating clearly what it believes the Civil Service is for, how it must change and with a timetable of clear milestones. Such a change programme would enable real change in Whitehall and avoid the fate of previous unsuccessful reform initiatives,” Change in Government: the Agenda for Leadership, September 2011. The situation is similar regarding the introduction of integrated services.

2.7 The Health and Social Care Bill also offers the opportunity to integrate health and social care in other ways, for example through the leading role local government will be given. Health and Wellbeing Boards in particular will play a key role in driving integration and partnership working between the NHS, social care, public health and other local services. However in order to achieve this goal, they will need to have a strategic focus, cross-agency involvement, and to be given status and power that will enable them to engage effectively with the various other organisations and regulators involved.

3.0 FINANCIAL DISTRESS AND POSSIBLE FAILURE

3.1 If our remit were to be extended to social care, the changes to the Health and Social Care Bill mean that Monitor could have a role in ensuring the continuity of provision of services in larger care providers in the event of a financial failure such as Southern Cross.

3.2 As sector regulator Monitor would undertake market surveillance to determine the financial viability of all providers of “commissioner requested services” (CRS)—in effect those NHS services that are regarded as essential for local communities.

3.3 If a similar process was introduced for social care, Monitor’s role would be to support commissioners in ensuring continuity of service for the safety and wellbeing of residents and patients. Given the large number of social care providers and the significant commissioning capability of local government we are expecting only a limited number of cases where our oversight might be of value.

3.4 Licensing will be the mechanism which ensures that Monitor can support commissioners effectively in securing continued access to NHS services. For example, conditions might be included in standard or special license conditions that would reduce the risk of problems arising in the first place.

3.5 In the event that we were to become concerned that any organisation delivering commissioner requested services was in distress, we would have powers to work with the provider and commissioners, both to attempt to resolve the situation and to plan for the worst eventuality.

4.0 MONITOR’S APPROACH

4.1 Much of the detail of how we would carry out our role in regard to social care if were to be given this remit, is something we will need to work out. However, our absolute priority would be that everything we do must be driven by what is best for patients.

4.2 Our role would be to support commissioners of care.

4.3 Supporting this, there are a number of principles we would be guided by in carrying out our proposed new role:

— we would be measured in the steps we take;
— we would do our best to take account of the capacity of the system to change and to balance this against the need for change;
— we would make decisions on the basis of evidence and facilitate the collection of new evidence where it doesn’t currently exist;
— we would also be alive to the specific circumstances of health and social care, even as we seek to learn lessons from elsewhere; and
— we would make sure we consult widely before acting, so that all relevant voices are listened to.

October 2011

Written evidence from Papworth Trust (SC 15)

BACKGROUND

1. Papworth Trust is a disability charity and registered social landlord, whose aim is for disabled people to have equality, choice and independence. Papworth Trust helps over 20,000 people every year through a wide range of services including employment, vocational rehabilitation, housing and personal support.

2. Papworth Trust is strongly committed to delivering high-quality, personalised care and support to our service users, ensuring that this ethos is at the heart of all our services to enable disabled people to have a bigger say over what happens in their lives and across our organisation.

SUMMARY

— Personal Budgets are well-used by those that uptake them, but the choice not to have one must remain for individuals who do not want one.
— Personal Budget users are also unfairly penalised by paying VAT for services which Local Authorities are able to reclaim VAT for.
— Personalisation will, crucially, require a personalised service integrated across social care, health, housing and welfare.
— Pooling budgets between health and social care could provide savings for the NHS by paying for measures that prevent costly hospital admissions.
— Papworth Trust welcomes the Dilnot Commission’s recommendations but is concerned that the cost to implement them is unlikely to be met in the current economic climate.
— The lack of portability of assessments is a major barrier to choice and independence. A person’s social care requirements rather than funding should be consistent when moving between Local Authorities. This could be aided by making equipment and data portable.

**PERSONALISATION**

3. Papworth Trust is strongly committed to the personalisation agenda and, where possible, tries to tailor services to meet the lifestyle needs of our clients enabling them to meet their aspirations. We believe disabled people should be given greater choice and control over what happens in their lives. We welcome the Government’s move in the provision of adult social care to a model that is designed around the needs of the individual.

4. The greatest challenge facing personalisation is a lack of available funding for Local Authorities to implement it. As Local Authorities seek to make savings, social care budgets are being stretched or cut. Government must ensure that Personal Budgets are not forced upon individuals as a way for Local Authorities to make cuts in their provision of social care.

5. Papworth Trust’s experience of Personal Budgets is mixed, though we have found that they are well-used and are personal for those that use them. We believe that Personal Budgets are an excellent tool for encouraging choice, however the choice not to take one up must also be retained. Personal Budgets are not suitable for all people, as some may find them difficult to understand or are happy with the services they already receive. For people receiving end of life care, Personal Budgets may be not appropriate for what are often short-term and quickly changing care requirements. How “personal” a Personal Budget is also depends on the individual having choice and control over their daily lives and care needs, without which personalisation may have minimal impact. Local Authorities have an obligation to offer Personal Budgets to all of their adult social care recipients by 2013. Care must be taken to ensure that these offers are not forced upon individuals in order for Local Authorities to save money.

6. As a provider of day services, Papworth Trust has discovered an adverse VAT loop hole for clients purchasing our services using their Personal Budget. Both Local Authorities and clients using a Personal Budget pay VAT when purchasing certain day services. However Local Authorities are able to recover the VAT, whereas individuals cannot. This means Personal Budget holders do not receive maximum value for money and are charged more than a Local Authority for the same service. This is further complicated by the fact that our day services include both VAT exempt welfare activities and VAT liable vocational training.

7. We also experience great difficulty in deciding when to charge VAT for day services, particularly for activities which can be classed as both welfare and training, such as life skills like literacy and numeracy. We urge the Government to address this issue quickly by enabling individuals with Personal Budgets to recover VAT for day services and clarify VAT liability for day services which could have either welfare or training intentions.

8. There are limitations to what Personal Budgets can be used to purchase outside of social care which may also improve wellbeing. This can be a problem particularly for people with mental health conditions where complimentary therapies, owning a pet or visiting their parents can all be beneficial to their health and wellbeing, but incur costs not covered under Personal Budgets.

9. Finally, Papworth Trust believes that Personal Budgets should not be the only route to achieving personalisation in social care. Instead personalisation is required across a range of integrated services to reduce bureaucracy, cut costs and provide the individual with a truly personal service.

**INTEGRATION**

10. A personalised service would see integration across health, social care, welfare, and housing. Personalisation, by definition, promotes the principles of individual choice, decentralisation of services, fairer access to services and a more diverse range of providers. These principles were outlined by the Government earlier this year in its vision of public services delivery in the Open Public Services White Paper. The Paper outlines how these principles could be applied by categorising public services into three areas; individual, neighbourhood and commissioned services with decision-making devolved to the lowest level wherever possible. Papworth Trust welcomes these proposals and strongly believes that this cross-service approach is necessary for personalisation and integration to be entrenched in public service provision.

11. Integration is a challenge facing Government which requires a radical change in the mind sets of those delivering public services and current working practices which focus on individual services rather than individual services rather than...

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individuals. With the increasing pressure of an ageing population we can no longer treat health and social care as separate areas. Papworth Trust welcomes the introduction of Health and Wellbeing Boards which provide an excellent opportunity to further integrate these services. We urge the Government to expand the membership of the Boards to include representatives from social housing and welfare to ensure that the Boards’ focus is on the social model and not medical model of disability. A person’s health and wellbeing is of course increased by receiving quality health and social care services, but also by living in suitable accommodation for their needs, and having the ability to contribute to society, including through employment. Therefore we urge the Government to promote integration by ensuring that all of these factors are considered by Health and Wellbeing Boards, and in its wider approach to social care.

12. Health and social care services may be further integrated by the pooling of budgets. For example, the NHS could fund aspects of social care for individuals who would otherwise end up in hospital at a much greater cost to the NHS. Another preventative measure could be the NHS’ use of Home Improvement Agencies to provide adaptations to a person’s home which enables them to live independently and improve their wellbeing, greatly decreasing their chance of being hospitalised, thus creating an overall saving for the NHS. Currently hospitals are not incentivised to prevent admissions from people receiving social care, as they are paid by results. We therefore urge the Government to look at ways the NHS could be encouraged to support social care and housing in order to reduce its own costs.

13. Better integration is not simply the responsibility of Government, but also of the providers, private sector and Third Sector as a whole. This may include streamlining and merging functions of the back office between organisations. Charities should consider moving away from a condition or impairment focus to looking at the support individuals require across health, social care, welfare and housing.

Dilnot Commission Report on Social care Funding

14. Papworth Trust supports the recommendations of the Dilnot Commission’s Report in principle but is unsure how realistic they are given the current economic climate. We are concerned that at £2 billion per year to implement and during a time of economic uncertainty and cuts, it is unrealistic to ask the Government to more than double its spending in one area. There has been little commentary on the recommendations since its publication in July and urge the Government to update the sector on what its intentions are.

Portability of Assessments

15. The lack of portability of assessments across Local Authorities is of concern to Papworth Trust and a major barrier to choice and independence for recipients of social care. Under the current system, when a person with care needs decides to move, a decision is taken by the new Local Authority as to whether they will pick up the individual’s care costs after an assessment, causing anxiety and restricting choice. We welcome the Dilnot Commission’s proposal to rectify this failure of the existing system with portable assessments, ensuring that a disabled person is given the freedom and choice to move around the country and still have their care needs supported.

16. No matter where a person lives or chooses to move to they should be entitled to consistent provision for their needs and quality of care. Some Local Authorities’ use of a person’s place of ordinary residence to dispute or prevent having to pay for their care, causes unnecessary distress for many people, is discriminatory and unfair. Despite the Government’s revision of the guidance for the definition of ordinary residence in April 2010, Local Authority disputes over responsibility remain. One solution to preventing these disputes would be to make the guidance legally binding, ensuring that Local Authorities’ obligations to provide care and support for people moving into their area cannot be overlooked or challenged. The greatest barrier to making care portable is the attitude of Local Authorities who must become customer centred and willing to serve a customer no matter what their circumstances are.

17. Papworth Trust believes that along with assessments, equipment and data should also be portable to reduce costs and bureaucracy for Local Authorities, and assist individuals in moving to another Local Authority. Instant savings can be made by better integration of the system. For example, equipment such as hospital beds which have been set up for an individual’s needs could be transferred, rather than be returned to the Local Authority and a new one requested from the new Authority, which must then be set up again to the individual’s requirements at a greater cost to the Government and inconvenience to the individual.

18. Papworth Trust believes that a person’s social care funding should not necessarily follow them from one Local Authority to another. Although we are not against portable funding in principle, it may not be practical for either the individual or Local Authorities. For example, someone moving from Newcastle to London with the same level of funding following them would not receive the same level of care because of the higher cost of services in London. Instead we propose that a person’s care and support needs should follow them between Authorities, assisted by the use of data sharing between Local Authorities. If a person requires 50 hours of care a week, this need will not change when they move to a new Authority and it is this that should be portable. This can be achieved by sharing data on an individual’s current care package with the new Local Authority, ensuring that the same care package is in place for their arrival. The Local Authority’s care manager would then work with the individual to ensure the package is value-for-money and cost efficient for both the Local

51 Voluntary Organisations Disability Group, Not In My Backyard: Ordinary residence, Discrimination and Disabled people, 2011.
Authority and customer. This would remove the gap in support created while waiting for an assessment by the new Authority and instantly reduce the anxiety caused by this waiting period.

Conclusion

19. The Government must ensure that momentum is maintained in its commitment to reforming social care and implementing the Dilnot Commission’s recommendations. Papworth Trust supports the need for urgent reform of the social care system and believes that any reform should strongly encourage greater integration between health, social care, welfare and housing services and between Local Authorities in order to provide the person-centred approach which has been promised with the introduction of personalisation.

October 2011

Written evidence from Mencap (SC 16)

Mencap is the UK’s leading learning disability charity, working with people with a learning disability, their families and carers. We want a world where people with a learning disability are valued equally, listened to and included. We want everyone to have the opportunity to achieve the things they want from life.

Executive Summary

1. In Mencap’s response the key points are:
2. With the growing demand on services and the wider financial strain on frontline services, the social care system is in crisis and in need of urgent reform.
3. Social care is chronically underfunded and in need of urgent reform by the Government. Mencap supports the observations and recommendations of the Dilnot Commission.
4. The legal framework around social care is complex, confusing and at times contradictory. Mencap supports the recommendations by the Law Commission to create a single statute which incorporates the 60 years of social care legislation along with the key developments in policy over this time.
5. The social care system has been heavily subjected to huge variation in the access to and charging for social care. This “postcode lottery” has got worse since the recent round of local authority budget setting, where councils were under pressure to make major savings. Mencap calls for a national system of assessment along with a national eligibility system and a national resource allocation system. We also call for clearer statutory guidance on charging for social care.
6. Mencap is very worried about the tightening of eligibility criteria, by local authorities and the impact this is going to have on the lives of people with a learning disability.
7. Current ordinary residence and portability rules are letting people with a learning disability, and their families, down. The Government must take on board the observations and recommendations of the two Commissions when publishing the upcoming white paper.
8. Personalisation can have a major impact on the lives of people with a learning disability, giving them greater choice and control over their lives. However the Government needs to address the weaknesses in the system and patterns of poor practice in the future white paper. They also need to address the growing number of cases where personal budgets have been used to implement cuts in social care services for individuals.
9. Where health and social care agencies are joined up in their work, people with a learning disability reap the reward. However the future white paper needs to seriously look at the current practice of joined up work and seek ways to remove barriers to effective partnerships.

Response

10. Introduction

11. The social care system, in England, is in crisis and in need of urgent reform.
12. Too many people with a learning disability are left behind by the current social care system because it is underfunded and based on a complex and at times contradictory legal framework.
13. As the demand on social care by people with a learning disability is increasing, more people are set to be left behind without the care and support that they need. Eligibility criteria, failures of information and support services and poor services have prevented many individuals from having choice, control and independence in their lives. Ending this should be the priority for proposed reforms.
14. In 2009 and again in 2011, Mencap held a consultation with people with a learning disability, families, carers, experts and sector workers, which received over 1200 submissions. The consultation was held to

33 Mencap’s Don’t cut us out! Consultation, 2009 (updated 2011).
establish a true picture of social care services for people with a learning disability and identify areas for reform in light of the Government’s 2009 green paper. Results showed the vital role that social care has on the daily life of many people with a learning disability, where it enables people to live independently and play an active role in society. However responses to the consultation identified many areas which are not working well. The results from the consultation have fed into our policy and form the basis of this response. Please see the appendix for the main findings of the consultation.

15. Mencap welcomes the Government’s commitment and approach to reforming the way adult social care is funded, in particular we welcome the work of the Commission on the Future Funding of Adult Social Care and the Law Commission to reform a system for the elderly and working age adults. We were pleased that both Commissions recognised the challenges and opportunities as an issue for adults of working age, whereas previous reform proposals had not.

16. Current plans for reform

17. The social care system is no longer able to cope with the rapidly ageing population and with the increasing numbers of people who are living longer with illness and disability. There is a growing demand on social care services by an increasing number of people with a learning disability.

18. We believe that there is a significant appetite for reform amongst those affected by social care and amongst the general public. Families will no longer tolerate a social care system which leaves many with no support and others with poor quality services. The public are angry that they can face huge care charges, and end up losing all their savings or being forced to sell their homes.

19. Mencap urges the Select Committee to hold the Government to account if there is a failure to urgently address the failures of the current system.

20. Commission on funding—Dilnot Commission

21. Mencap, along with other members of the Care and Support Alliance welcomes the observations made and the subsequent recommendations by the Commission of the Future Funding of Adult Social Care (known as the Dilnot Commission herein). The Dilnot recommendations are a practical and fair way forward, which present a fairer way to share the costs of care between individuals and the state, protecting everyone from catastrophic care costs and ensuring that low-income families and younger disabled people are supported.

22. Most importantly the Commission recognises that the current system is chronically underfunded and in need of urgent reform.

23. We encourage the Health Select Committee to support the work of the Commission and endorse its proposals.

24. Law Commission

25. Mencap supports the Law Commission’s view that there is low awareness of how the current system works and that it is complex and difficult to navigate. During Mencap’s social care consultation, many individuals told Mencap that one of the greatest barriers to social care is the lack of information and support to the individual and the family. This includes a failure to provide accessible advice and information and often a complete failure to provide any information and support.

26. Mencap welcomes the recommendations made by the Law Commission, in particular the proposal to create a single statute for adult social care regulated through a three-level structure of statute, regulations and guidance. We believe that this will go some way to make the system more transparent and fair.

27. We believe that the Commission has produced a strong set of recommendations encapsulating the legal framework and developments in policy and practice in the last 60 years, some of which we will explore under other headings. However, there are a couple of areas that we would have liked the recommendations from the Law Commission to have gone further, including a reform of the ordinary residence rules and the duties placed on local authorities to record the numbers of people who are disabled.

28. Furthermore to go beyond the work of the Law Commission, Mencap urges the Government to address the barrier of the lack of information on the “entitlements” to services and support in the upcoming white paper. These underpin the social care agenda and should form a key part of any reform. Mencap calls for all local authorities to provide free independent advocacy to all individuals who require care and support and a duty on local authorities to provide good quality accessible information at all stages of the care and support process.

29. Variation in access to and charges for social care in England

30. Mencap believes that the current legislation and statutory guidance governing the access to and charges for adult social care is interpreted differently by local authorities. This has led to what has been dubbed a “postcode lottery” of social care.

34 Department of Health: Shaping the Future of Care Together 2009.
31. Eligibility

Mencap is very concerned about the varying levels of access to social care. The postcode lottery makes it difficult to have a system that is fair and equitable. The Government should consider the merits of a national eligibility system and national resource allocation system in the expected white paper.

Mencap urges the Select Committee to make strong recommendations in this area, which should aim to encourage the Government to address this issue seriously. The future reforms are a good opportunity to tighten the way local authorities interpret the guidance.

34. Tightening of eligibility and access to services

Mencap is becoming increasingly concerned about the tightening of eligibility criteria that is taking place in many local authorities.

We are concerned about the exclusion of many people with a learning disability from the current social care system because of eligibility criteria, a symptom of an under-funded system. Research by Mencap found that 11% of local authorities have tightened their eligibility criteria since April 2011. 35

Mencap is concerned about the increasing number of local authorities that are considering changing their commissioning policies to exclusively provide care and support to individuals in the critical band of eligibility only.

Variation in charging

Mencap is very concerned about the varying levels of access to social care. The postcode lottery makes it difficult to have a system that is fair and equitable. The Government should consider the merits of a national eligibility system and national resource allocation system in the expected white paper.

We believe that the problems associated with the wide interpretation of charging guidance could be dealt with by clearer and tighter statutory guidance.

Mencap believes that the issue of ordinary residence and portability needs to be urgently addressed in the Government’s social care white paper.

The current legal standing of ordinary residence is complex, unclear and has had a negative impact on the lives of people with a learning disability. Many people with a learning disability have found themselves trapped somewhere that they don’t want to live, whilst local authorities dispute over who is going to pay for the individuals care. This is a common situation for people who live in a residential care home not based in the area in which they originally lived. When the residential care home closes or the individual wishes to move to a different area, they can find themselves stuck somewhere that they don’t want to live.

41. Ordinary residence and portability

Mencap submitted FOI requests to all social care providing local authorities, other than Isle of Scilly. The FOI received a very high response rate with 97% (148). For the 4 local authorities, who did not send coherent response, or failed to respond, we undertook independent research to complete the study.

35 Mencap submitted FOI requests to all social care providing local authorities, other than Isle of Scilly. The FOI received a very high response rate with 97% (148). For the 4 local authorities, who did not send coherent response, or failed to respond, we undertook independent research to complete the study.

36 Ibid.

37 Commission for Social Care Inspection, Cutting the Cake Fairly, CSCI review of eligibility criteria for social care (2008).

38 Don’t cut us out! Mencap’s consultation on adult social care (2009).
to a different form of supported living, the original local authority and the local authority of the care home enters a lengthy battle over who will be providing the new package.

44. In relation to portability, individuals and families have told Mencap that their human rights were being ignored as they were effectively imprisoned in their local area, because packages are not portable. On many occasions, where the individuals have moved, they and family carers had to battle to get the care and support that they need and often had to settle for a lower level of care in the new package.

45. Mencap would like to see a National Assessment System, alongside a national system of eligibility and resource allocation, where individuals can move with their care package without fear of losing their care and support. This could set the national standards and expectation for local authorities to administer locally.

46. One of the greatest barriers to moving is the failure of local authorities to work with each other. Mencap welcomes the recommended duty to cooperate by the Law Commission and encourages the Select Committee to also recommend this.

47. Personalisation

48. Mencap fully supports the Government’s commitment to personalisation, as it reinforces the concept that the individual is best placed to know what they need and how those needs can be best met. Personalisation is about giving people greater choice and control over their lives and replaces traditional and institutional care services. Where it is done properly, personalisation can make have an incredible impact on the life of the individual.

49. However Mencap has some serious concerns about some aspects of how the personalisation agenda is being implemented. During Mencap’s consultation on adult social care, many people with a learning disability and their families told Mencap about how they have been left out of personalisation. This scenario was also highlighted by a CSCI report, which found that many local authorities have failed to make substantial changes to introduce person-centred care, creating unfairness in the social care system.

50. Personalisation, like other aspects of social care, is subject to the post code lottery. Mencap believes this to be a direct result of local flexibility and a lack of transparency. As outlined above Mencap strongly calls for a national assessment system, which would increase transparency and alleviate the postcode lottery.

51. This year saw the end of the use of National Indicators, which recorded the growth in usage of self-directed support, namely direct payments and individual budgets. We are concerned that this is going to make it difficult for the Government to have a clear idea as to the progress of it’s policy. Mencap calls for the Department of Health to take on a more proactive approach in monitoring and enforcing the efforts made by local authorities to introduce personalisation in their area.

52. Personal budgets and cuts

53. Mencap was one of the original founders of In-Control, which lead to the introduction of Individual Budgets. The key principle behind them was self-directed support.

54. Personal budgets and individual budgets are ways in which personalisation is often practiced. Too often personal budgets tend to be an exercise in costing packages of care, and then driving them down to the average cost of a particular need. As such, some local authorities have used personal budgets, primarily to save money.

55. We are also concerned that many local authorities calculate an individual’s budget based on what they currently spend, minus the additional costs accrued by the local authority for providing the care in a traditional care package, including the administrative costs, and then allocate an amount which ultimately reduces the money spent on the individual. In fact, Mencap has been contacted by several individuals and their families who believe that their council is significantly reducing the level of care that they receive since being given a personal budget or direct payment.

56. To be truly personalised we believe that personal budgets should not be calculated in this way, instead they should be based on the value of the services that the individual needs and wants and the market rate for providing these services:

Case study

Susie is 47 years old and has a severe learning disability. For all of her adult life, Susie has been in receipt of social care services, where she has attended a day centre five days a week. Although the council are not closing the day centre, they wanted to offer Susie the opportunity to have a personal budget for her care and support. Excited by the option Susie accepted, with support from her family. After being reassessed, the LA gave Susie the financial budget which was the amounted to only one and half days worth of day services. This is a major cut in the level of support that Susie received, even though her needs have not changed.

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41 Mencap response to the DH consultation: The case for chang—why England needs a new care and support system, 2008.
57. Whilst there are some savings to be made, individuals must continue to receive the level of care that they are assessed as needing no matter how they receive their service. Mencap believes that due to the growing demand on services, any savings made from changes to social care packages, should be reinvested into the social care budget.

58. **Joined up working**

59. Mencap firmly supports the importance placed in policy on joint working when it comes to social care. A real difference can be made to the lives of people with a learning disability, if all agencies work together, particularly to people with complex packages of care. People who took part in Mencap’s consultation called for greater joined-up working. Too many are tired of rigorous form filling, telling their story to dozens of key workers and being given conflicting advice. Joint working, and the failure to do so, has an impact on all parts of a person’s life. It can make the difference between someone being enabled to live independently or losing his life.

60. We have also learnt from the experiences of some, that a failure to work together can put an individual at risk. The cases of Francesca Hardwick and her mother Fiona Pilkington, as well as Steven Hoskin provide clear examples of where a breakdown in communication and joint working between local agencies can lead to serious consequences, in these cases resulting in a loss of life.

61. Mencap believes that the Government will need to provide clear leadership on the matter in the white paper and following Bill. All agencies need to fully understand what is expected of them and what they are legally responsible for, particular around areas of safeguarding. Mencap supports the Law Commission’s recommendations in this matter, in particular an enhanced duty to cooperate, which we believe should be led by local authorities.

62. Furthermore, Mencap believes the way the funding is given to support joint working is a barrier to its success.

63. Many health and social care authorities have joint or pooled budgets. When money is tight, this can still lead to disputes. Mencap urges the Government to look at the learnings from the transfer of funding for NHS campuses from the NHS to local authorities as to identify ways to pool resources. We also urge further consideration to be made for the idea of a pooled budget to fund joint working.

*October 2011*

**APPENDIX**

**MENCAP’S DON’T CUT US OUT! CONSULTATION**

Between 15 July and 31 October 2009 and again in October 2011, Mencap held a consultation entitled Don’t cut us out! The consultation, aimed at people with a learning disability, their families and carers, services providers and members of the public, asked individuals to share with Mencap their views and experiences of adult social care in England. Over 1,200 submissions were made.

Mencap’s consultation used a wide range of mechanisms to reach as many people as possible. These are shown below:

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<tr>
<th>Online</th>
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<tbody>
<tr>
<td>Public online survey</td>
<td>Standard survey</td>
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<tr>
<td>People with a learning disability online survey</td>
<td>Easy read survey</td>
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<tr>
<td>Carers and family members online survey</td>
<td>Postcard</td>
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<tr>
<td>Local group online survey</td>
<td>MNA/AGM standard survey</td>
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<tr>
<td>E-forum</td>
<td>MNA/AGM easy read survey</td>
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<td>Transition survey</td>
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<th>Interactive</th>
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<td>Focus groups</td>
<td>Case studies</td>
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<td>Interviews</td>
<td>Text service</td>
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<td>Video submission</td>
<td>Emails/letter submission</td>
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<tr>
<td>LGA conference questionnaire</td>
<td>3 party conferences</td>
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42 Francesca Hardwick and her mother, Fiona Pilkington, died in 2007 after Fiona set fire to their car in a Leicestershire lay-by. Despite repeated complaints to the police, the family had suffered years of abuse from a gang of up to 16 youths who reportedly threw stones, eggs and flour at the family home. [www.equalityhumanrights.com/media-centre/council-s-compliance-with-disability-equality-duty-to-be-checked-following-inquest-findings/](http://www.equalityhumanrights.com/media-centre/council-s-compliance-with-disability-equality-duty-to-be-checked-following-inquest-findings/)

43 Steven Hoskin (2006), violently tortured before being forced to take a lethal dose of painkillers and fall from a bridge to his death.
Focus groups, online public survey and postcards have been the three most popular ways for people to take part.

**Top 10 Issues:**

1. **Choice**
   - Lack of choice of services. This was raised by all sections of participants. Many participants supported personalisation but felt that there was not enough choice to meet their needs. Many who do not get a service felt that their “life choices” were limited as there is no support.

2. **Funding**
   - The majority of contributions highlight the need for more funding or raises issues that are a direct result of an underfunded system. Some individuals and local groups have called for ringfencing of social care budgets.

3. **Employment**
   - This issue was raised mainly by people with a learning disability and family carers. Many discussed the need to get more people with a learning disability into employment. It was clear that many people face barriers to getting a job, which more support and Government action to would erode.

4. **Housing**
   - There was a significant call for more supported living schemes; people with a learning disability want choice about where they live and who they live with.

5. **Postcode lottery (and portability of care packages)**
   - The online public survey highlighted the issue of the services available, quality of services and eligibility criteria being subject to a postcard lottery. All comments on this issue recognised the unfairness of this and calls for the Government to make a priority out of addressing this inconsistency.

6. **Skills of the social care workforce**
   - Many participants who are people with a learning disability wanted to have a better relationship with their support worker and social care staff. Some never have the same support worker everyday and others felt that their support worker did not understand them.
   - The public poll, local groups and carers/families’ poll highlighted the need to increase the skills and understanding of the social care workforce. There was also a general feeling that “grass roots” staff needed to be consulted more for local decision making.

7. **Information and advice**
   - An issue raised in all areas of the consultation: information and advice should be widely available, easy to understand and of good quality.

8. **Involve me and my carer in decisions**
   - There was a strong feeling that people with a learning disability and their carers are excluded from making decisions about their care.
   - It was also a common theme that more power should be given to partnership boards; Government should ensure that local authorities truly involve pwld and carers throughout all decisions on learning disability.

9. **Public awareness**
   - There was a great consensus in the call for the Government to increase public awareness on learning disability. Many felt that if the public were more aware of the issues for people with a learning disability there would be greater support for a larger social care budget. Increased public awareness would also help people to get a job, reduce hate crime and would help to include people with a learning disability in the community.

10. **Bureaucracy**
    - This is mainly in relation to the “fight” that people face when applying for a social care service and the process that they endured. It also refers to the complexity of the benefits system. It was felt that the complexity of the forms, meetings and regular reviews excluded some individuals from receiving social care. Some people with a learning disability and carers relayed the stress that they suffered whilst applying for social care.

The next 15 top common themes* (listed in order of frequency):

- Transition.
- Respite care.
- Desire to be independent.
- Advocacy.
- Eligibility.
- Assessment process.
- Need for better joined up working.
- Older people with a learning disability.
- Push for more personalisation (inc. Individual Budgets).
- Simplify benefits system.
- Cuts to services (esp. day centres).
- Safeguarding.
- Out of hours care.
— Better monitoring of local authorities.
— Better guidance for local authorities.

* More issues were mentioned.

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**Written evidence from Wendy Regaard (SC 18)**

**A CARER’S EXPERIENCE OF END OF LIFE CARE IN OXFORDSHIRE, SEPTEMBER 2010 TO MAY 2011**

I am a woman of 75 who looked after my husband of 82 at home until shortly before he died of metastatic melanoma in May 2011.

I would like to make the following points. They are mainly about lack of clarity and consistency:

1. The Committee will already be aware that care provision for people with a variety of needs is fragmented, inconsistent from area to area and difficult for the average person to understand. However, what the Committee may not fully appreciate is the toll of exhaustion, bewilderment and helplessness that this lack of clarity engenders.

2. The role of Macmillan nurses was not in our experience anything like the public perception. They rarely visited and certainly did not have a co-ordinating function.

3. The role of the GP is not at all clear. It seemed as if they were unwilling or unable to point us in the right direction, even though the assumption is that they do so. Their ability to communicate with the dying and their relatives is variable.

4. Assessment of need is patchy. We were never clear as to whether it was the GP, the District Nurse or the County Council adult care team who was responsible. We spent long periods on the telephone, often with messages not being passed on.

5. Co-ordination of the provision of aids was generally poor. Usually it was a matter of too little, too late. Sometimes we had to provide them ourselves, buying them at chemists’ shops or hiring from the Red Cross. I was willing to do this, but the situation about availability should have been made clear. It was particularly difficult when needs arose on Bank Holidays.

6. As a family, we were not at all confident that there was enough, or any, expertise in palliative care. This is a matter for specialist training. Certainly the staff who came from the Care Agency eventually provided by the County Council appeared to have limited skill in communicating with the dying and their family, although they were well-intentioned.

7. There appears to be an assumption that dying at home is the preferred option. This may be so, but under present conditions I think it is not a well-founded aspiration. A death in a busy acute ward is probably not ideal, and is costly, but the prospect of a death at home, unless one is confident about rapid support and help, with the patient and carer left on their own for long periods, can be daunting.

8. In our case, a Marie Curie nurse was provided at night for a few nights. This was a great relief, but I was initially told that I could not rely on the service every night.

9. Inconsistency of policy information had an unfortunate consequence. Until the Marie Curie nurses came, I had been sleeping near my husband, getting up several times at night because he was trying to get out of bed. I asked for sides to be fitted to the bed, but was told by the Care Agency that they could not be provided because they were a form of restraint or entrapment. When a falls specialist eventually visited (a long time after the request), she said this was not the policy and the cot sides arrived, but it was too late for us.

10. A death in a Hospice is kind and merciful, but it is by no means certain that there will be a bed available when the time comes. In our case we were fortunate, but the uncertainty was difficult and when the time came my husband was almost too ill to leave home.

11. I wish I had not felt moved to write this Memorandum, as it has been difficult. I am not writing it out of emotion, but out of a wish to do anything I can, however small, to enable others to have a better experience. I am not making any special pleading in our own case.

I am fully aware of the Government’s need to cut costs, but I suggest that efficiencies are only likely when there is:

— streamlined provision (I know this will be difficult);
— a named individual to help families to navigate their way through the system; and
— better training at all levels, especially in communication.

At the present time, I do not see how the provision of a personalised budget could have done anything but add to the family’s burdens. Perhaps, with guidance, it might have helped. I have no wish to address particular
complaints to any individuals, or towards specific parts of the system, because I do not think it would be effective except in raising the existing levels of stress in the staff.

October 2011

Written evidence from the Motor Neurone Disease Association (SC 20)

Executive Summary

(i) High quality social care brings significant benefits not only to the person in receipt of it, but also to the NHS and to society and the economy more broadly. The funding of social care is currently at issue: the Government faces an important choice.

(ii) We do not believe social care is adequately funded at present. We support the findings and recommendations of the Dilnot review and Law Commission review, and do not believe that an exercise to seek new solutions is needed.

(iii) Personalised care can be transformative for people with MND, but it must never be compulsory or used to cover for cuts. It will be particularly welcome if personal health budgets can ease the sometimes difficult transition between social care and NHS continuing healthcare.

(iv) In a settlement where both are run along market lines, health and social care can only be integrated via commercial drivers. Mechanisms for integration currently proposed seem unlikely to override market forces.

Introduction

1. Few conditions are as devastating as motor neurone disease (MND). It is rapidly progressive in the majority of cases, and is always fatal. Patients will, in varying sequences and combinations, lose the ability to speak, swallow and use their limbs; the most common cause of death is respiratory failure. Most commonly the individual will remain mentally alert as they become trapped within a failing body, although some suffer from dementia or cognitive change. There are about 5,000 people living with MND in the UK. Half of people with the disease die within 14 months of diagnosis. There is no effective curative treatment.

2. The MND Association is the only national organisation supporting people affected by MND in England, Wales and Northern Ireland, with approximately 90 volunteer led branches and 3,000 volunteers. The MND Association’s vision is of a World Free of MND. Until that time we will do everything we can to enable everyone with MND to receive the best care, achieve the highest quality of life possible and to die with dignity.

3. This submission covers selected areas of the call for evidence; we have no comment to make at present on those areas not addressed.

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

4. A well-functioning and adequately funded social care system will bring significant practical benefits. Effective social care enables people with MND to live safely in their own homes, and reduces costs to the NHS by minimising the need for emergency admissions due to falls, choking incidents and so on, while also allowing prompt discharge when such an incident has occurred rather than blocking an expensive hospital bed. It is essential to securing as high a quality of life possible, for as long as possible, in the face of a ferocious and devastating disease.

5. Effective social care will also ensure the ongoing wellbeing of carers for people with MND: by ensuring the burden on them is not intolerable, it reduces their need to call on the NHS for problems of their own, and in the case of people of working age who develop MND can allow carers to re-enter the labour market more easily once their caring role has ended.

6. It is therefore clear that whatever decisions the Government takes in respect of the funding of social care, and the Law Commission recommendations, will have significant and far-reaching consequences, not only in the immediate term for people who rely on social care—crucially important though that consideration is—but in the NHS and in the wider economy.

7. We therefore believe that a significant investment in social care is necessary. To date the Government’s only decision has been to cut local authority funding by 28% on average over four years, somewhat (but not comprehensively) palliated by an additional £2 billion added to the local authority grant. On this subject the Government’s “vision paper” declared that, “[w]ith the solid basis provided in the Spending Review for social care, there is no reason for councils to restrict support to those with the most intensive needs”. Undeniably a more positive policy decision is needed in response to the Dilnot Commission’s recommendations. The need for investment cannot be shirked: the choice facing the Government is one between investment now and scandal later.
8. With respect to the Law Commission recommendations, we recommend that the Government should implement them at the earliest opportunity: they enjoy broad support and are well-developed. A further round of engagement to develop new proposals is not necessary.

The practical and policy implications of the Government's commitment to promote personalisation of social care, including personal budgets and direct payments

9. The effect of personalised care delivery for people with MND can, at its best, be transformative. It can also, however, represent far more responsibility than a terminally ill person may wish to take on in their final months or years. We therefore recommend that the possibilities of personalisation should be explored fully, but that it should never be made compulsory: we are therefore uneasy at the Government's stated aim of providing direct payments to everyone who is eligible, seemingly whether they want them or not. Imposing a personalised solution against the wishes of the individual seems to us to be the very definition of missing the point.

10. For those who use personal budgets or direct payments for social care in particular, the prospect of personal health budgets will be welcome: currently when a person with MND reaches the stage in their illness where social care is no longer enough and they require NHS continuing healthcare (CHC), their personally tailored package of care is taken away and replaced with a more extensive but less specifically adapted NHS service. Some people with MND deliberately resist this for as long as possible, despite their growing need. Smoothing this transition between funding streams so that familiar and arrangements can be maintained will be positive.

11. To achieve high quality outcomes via personalised arrangements, high quality information, advice and brokerage must be available to the service user. Providing personalised delivery without these things can be cheaper than traditional delivery, but much less effective—personalisaiton should not be used as a mechanism for cuts in this way. Similarly a budget of a fixed amount is vulnerable to reduction, which the individual will then have to deal with: this is potentially a much cleaner way of managing budget reductions than would traditionally have been possible, and therefore a dangerous aspect of personalisation.

The practical and policy implications of the Government's stated commitment to promote integration between health and social care services

12. While we welcome the stated intention to integrate health and social care services, we must observe firstly that this is a policy aim so consensual as to be a platitude—nobody is seriously suggesting that services should be further fragmented—and secondly that the reform processes for the NHS and social care in England have been largely conducted within the two traditional silos.

13. When the reform processes are complete, both the NHS and social care will be run along commercial lines, with statutory bodies purchasing services from a mixed market of providers. Crucially however, the statutory bodies will not be the same ones, but Clinical Commissioning Groups for the NHS, and local authorities for social care; moreover, the funding mechanisms for health and social care will remain different, and both are likely to have tight funding settlements for years to come. In a commercial situation, this will be a significant and problematic combination of factors when it comes to integrating the two services.

14. There is already sustained cost-shunting between the NHS and adult social services: instances of hospital discharge being delayed because social services struggle to fund a package of care are on the increase; one of the “gaming” tactics used by local authorities to delay awards of social care packages is to require the social worker to consider approaching the NHS for CHC, knowing that it will not be granted; the NHS is tightening its allocation of CHC funding, leading to some people with MND “bouncing” between CHC and social services. In a commercial system, where commercial logic informs the actions of decision-makers, this will continue to be the case: there is no incentive for either side to collaborate, when this will cost them money.

15. Moreover, any activity that does not generate revenue directly is liable to be cut. Very often co-ordinating activity that aids integration falls into this category: we are aware of one recently-created Foundation Trust where an MND Care Centre Co-ordinator has been instructed not to attend the multi-disciplinary team meetings at which information is shared and care co-ordinated across different parts of the NHS and social services. Social care managers can also be prone to barring their staff from attending such meetings.

16. We have argued earlier in our response that effective social care can save the NHS money: if, however, social services and the NHS operate from totally different budgets, there is no incentive for social services to think in the long term: the consequences of failure impinge on the NHS’s budget, not theirs. With cash tight, therefore, social services focus on immediate-term needs, and operate in a model of crisis management, the costs of which are often passed on to the NHS.

17. We do not see how any of the mechanisms for integration so far proposed by the Government, such as Health and Wellbeing Boards, can override this commercial logic, despite the obvious impact on care for people who rely on services. In a market-driven care system, integration requires commercial drivers or it will not happen.

October 2011
Written evidence from United Kingdom Homecare Association (SC 21)

Executive Summary

— UKHCA is the professional association of homecare providers from the independent, voluntary, not-for-profit and statutory sectors. The Association represents over 1,900 member organisations across the United Kingdom. We welcome this opportunity to submit written evidence to the Health Committee’s inquiry into social care.

— UKHCA welcomes the recommendations of the Dilnot Commission on Funding of Care and Support. We see it as a crucial step forward to tackling the issue of funding care for our ageing population. However, the Commission has said very little on how we should ensure that there is sufficient and sustainable funding for the current scheme.

— UKHCA would like assurance that the eligibility threshold for social care in any new scheme will be set at a reasonable level, and certainly more generous than the very tight eligibility criteria currently operated by many councils. We would also like assurance that the proposed state-funded element will not be based on the current inadequate, and deteriorating, local authority care package.

— Any analysis of fees paid by local authorities to independent and voluntary sector providers, and to service users in receipt of direct payments must recognise that independent homecare providers are highly vulnerable to the purchasing decisions of the public sector. Even before the current economic downturn, providers were coming under increasing pressure from local authorities exercised by efficiency savings and reducing costs of services.

— UKHCA supports the delivery of more personalised health and social care services across the UK. However, it is important to recognise that there are significant risks and threats for home care providers from the way self-directed support is being implemented by some local authorities. Until now, these have been little acknowledged, but could potentially have important unintended consequences for the sector. At its most extreme, it “could spell large-scale destruction of the sector”.

— We believe it would be highly disproportionate for the failure of a large residential care provider to lead to the economic regulation of the homecare sector. What the homecare sector needs is not an economic regulator to monitor its finances, but for councils to pay providers sustainable fees that reflect the true cost of service provision.

— UKHCA supports the closer integration of health and social care to better meet the needs of individuals and provide an enhanced patient/user experience. We believe that integrated services are necessary to meet the increasing demands of an ageing population, especially in this time of economic austerity.

Recommendations made by the Dilnot Commission and Law Commission

1. UKHCA is the professional association of homecare providers from the independent, voluntary, not-for-profit and statutory sectors. The Association represents over 1,900 member organisations across the United Kingdom. We welcome this opportunity to submit written evidence to the Health Committee’s inquiry into social care.

2. UKHCA welcomes the recommendations of the Dilnot Commission on Funding of Care and Support. We see it as a crucial step forward to tackling the issue of funding care for our ageing population. We believe that the Commission has come up with workable proposals which promise sustainable care services for the future and clearly identify the balance of responsibility for the cost of care between the individual and the state. However, we believe that much more detailed work needs to be done on how the proposals will work in practice.

3. UKHCA agrees with the Commission that additional public funding for the current scheme is urgently needed. However, the Commission has said very little on how we should ensure that there is sufficient and sustainable funding for the current scheme. The whole focus of the Commission’s report is the future funding of long-term care.

4. The Commission has recommended that eligibility for social care should be set nationally and, until the current assessment system is replaced, the threshold should, at a minimum, be set at “substantial”. However, this will leave large numbers in need without state support until any new measure is developed. It is estimated that around 450,000 older people in need of care have some shortfall in the formal care they receive, with 275,000 older people with less intensive needs getting no support from their local council.


5. The Commission says that the state-funded care element should be based on a local authority care package, but people will be free to top up from their own resources should they wish. However, most local authorities (72%) only provide care support for those with “substantial” or “critical” needs.  

6. UKHCA would like assurance that the eligibility threshold for social care in any new scheme will be set at a reasonable level, and certainly more generous than the very tight eligibility criteria currently operated by many councils. UKHCA would also like assurance that the state-funded element will not be based on the current inadequate, and deteriorating, local authority care package. We would like to see a package of quality care that will enable those with less intense needs to live independently for longer in their homes and communities or in other services of their choice and delay or avoid many becoming dependent on others or the state. We would also like to see the increased use of reablement and preventative care and support.

7. The Commission believes that by capping the overall risk that people will face, new financial products could develop to support people in making their contribution to social care costs. However, it remains to be seen whether the insurance industry will rise to the challenge of providing new products for long term care. Part of the problem in the past was the difficulty of predicting just how much an individual’s care is going to cost, potentially exposing insurance companies to large indeterminate costs.

8. UKHCA has heard conflicting opinions from the insurance industry on the Commission’s recommendations. We have been told that the industry can come up with new financial products to cover the cost of care up to the £35,000 cap. However, we have also been told that the £35,000 is not insurable, principally because the council, and not the insurance company, will be responsible for carrying out the assessment of social care needs.

9. UKHCA supports the recommendations of the Law Commission. We believe it is correct to establish a unified adult social care statute, and that the overarching purpose of adult social care is to promote or contribute to the well-being of the individual. We also support the Commission’s other recommendations, including giving carers new legal rights, placing duties on councils and the NHS to work together, building a single, streamlined assessment and eligibility framework, and giving adult safeguarding a statutory footing.

CHARGES FOR SOCIAL CARE IN ENGLAND

10. Laing & Buisson’s 2009 domiciliary care market survey found that the average hourly charge for one daytime weekday homecare hour in England was £12.89 for local authorities and £12.98 for private purchasers. However, the variation in both fees paid and users’ abilities to access state funding is difficult to quantify.

11. Any analysis of fees paid by local authorities to independent and voluntary sector providers, and to service users in receipt of direct payments must recognise that independent homecare providers are highly vulnerable to the purchasing decisions of the public sector. Over half (55%) of independent providers are reliant on councils for 80% or more of their hours, and one in eight only have councils as hourly paying clients.

12. Even before the current economic downturn, providers were coming under increasing pressure from local authority commissioners exercised by efficiency savings and reducing costs of services. Local authorities’ annual contract price reviews barely recognised homecare providers’ additional statutory costs.

13. Other “cost saving” mechanisms used by local authority commissioners include only paying for contact time (sometimes only by the minute) or using short care episodes of 15 minutes for personal care. UKHCA’s commissioning survey (see below) found evidence that visits of 15 minutes were increasing rapidly, despite being widely discredited as poor practice.

14. In August, UKHCA undertook a study of the commissioning practices of local authorities to understand the impact of local authority commissioning decisions in the context of public spending cuts. It found that 82% of councils and health and social care trusts were reducing the number of hours of care they would pay for individual service users, and reducing the number of homecare visits people receive. Three-quarters (76%) were reducing the number of homecare visits that people receive by careworkers, with the average visit length (calculated from 50 case studies in the survey) falling by around 10 minutes, from 48 to 38 minutes.

15. UKHCA’s evidence on the increasing use of short care episodes is supported by an analysis of visit lengths undertaken for 35 local authorities by the private company CM2000 during one week in September 2010. Comparison with similar data from September 2009 shows an increase in both 15-minute and 30-minute visits and a decrease in 60-minute ones.

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49 United Kingdom Homecare Association Commissioning Survey 2011.
50 The survey was completed by UKHCA member organisations using an on-line data collection tool. In total, 158 providers responded to the survey, supplying 206 individual reports about 111 different councils or trusts.
16. We have heard from member organisations that some councils are employing a “Dutch auction” approach to social care, where local authority care contracts are won by the lowest price bid submitted in real time. E-auctions are a particular problem for small and medium enterprise homecare providers who may feel that their survival is based entirely on the public sector purchaser and that they are effectively forced into winning the contract at any price however low. The Scottish Parliament’s Local Government and Communities Committee investigated E-auctions in June 2009 and now no council in Scotland uses E-auctions for social care.

**PERSONALISATION OF SOCIAL CARE**

17. UKHCA supports the delivery of more personalised health and social care services across the UK. UKHCA was a signatory to Putting People First, and more recently the new sector-wide agreement transforming adult social care in England, Think Local, Act Personal. However, it is important to recognise that there are significant risks and threats for home care providers from the way that self-directed support is being implemented by some local authorities. Until now, these have been little acknowledged, but could potentially have important unintended consequences for the sector. At its most extreme, it “could spell large-scale destruction of the sector”.

18. Organisations that have been largely dependent on local authority purchasing may, within a relatively short period of time, lose contracts across the board, leading to a rapid reduction in guaranteed volume and therefore income. Many independent homecare providers are highly dependent on local authority contracts for their business. As mentioned above, over half are reliant on councils for 80% or more of their hours. For many, this loss of income could lead to closure.

19. Our point here is not a plea for inertia, but a caution about the rapid, and often uncoordinated way that councils are changing their contracting arrangements, leaving established providers with limited scope to source alternative revenue streams. In effect, the actions of some councils are destabilising their local care markets at the expense of adequate volume supply.

20. A critical question is the impact that the changes will have on social care capacity. There is no guarantee that staff will remain in the homecare sector if their original employer ceases trading. They may move out of social care altogether, thereby reducing overall capacity. Even where providers survive, some of the planned changes may make staff retention more difficult. Public sector contracts make it possible for providers to guarantee their front-line staff at least some work.

21. With the possibility of these guarantees gone or reduced there is likely to be more instability in the social care labour market and an increase in the churn of workers between employers. There is also likely to be less overall work on offer and possibly more fluctuation, which may lead to some care workers being lost to the industry.

22. One consequence of moving to self-directed support is that formal domiciliary care providers may lose staff to direct payment users. Member organisations tell us that the direct payment rates received by service users who have previously been their clients are usually not enough to enable them to continue to purchase their agency’s service unless they can afford to “top up” their care, ironic given the principle of direct payments is to extend service user choice.

23. Member organisations’ views are supported by a 2007 UK wide survey of direct payments which found substantial variation in the rates paid to service users, with many local authorities stating that payment rates were lower than the average costs of homecare providers. The researchers found the average hourly direct payment rate to an older person in England was £8.70. This compares unfavourably with £12.89 for state-funded homecare.

24. As a consequence of the low direct payment rates paid by councils, some service users are now directly employing the care worker originally introduced to them by their homecare agency. They are able to do this because they incur none of the agency’s overheads for training, registration and regulation. Self-directed employers are not required to provide training for their staff or to carry out security checks. It seems entirely illogical to UKHCA that government should have brought about a highly regulated sector from 2002, while at the same time, promoting a cash payment system for the engagement of untrained, unqualified, unsupported and unregulated personal assistants.

25. The direct employment of personal assistants by service users in social care has many characteristics of a grey employment market. While worker and employer will agree a wage rate that is acceptable to both, there is no guarantee that either will have an understanding of the National Minimum Wage, and the majority of service users, many of whom are extremely frail, may have little or no experience of acting as an employer.

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52 Think Local, Act Personal, January 2011
http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/THINK_LOCAL_ACT_PERSONAL_5_4_11.pdf


This has been confirmed by a number of studies showing that personal assistants are in very vulnerable employment situations.  

Barriers Faced by Recipients of Social Care when they Wish to Relocate to Another Area

26. This is not an area of UKHCA expertise and therefore we offer no comment on this question.

Economic Regulation including a Proportionate Failure Regime

27. The case of Southern Cross Healthcare case has raised the question of whether there is a need for an economic regulator to monitor the financial standing of private care providers, in particular the finances of large providers. UKHCA believes that it would be highly disproportionate for the failure of a large residential care provider to lead to the economic regulation of the homecare sector.

28. The problems of Southern Cross stemmed from unsustainable rent bills, falling bed occupancy rates and a drop in revenue from councils. What made it a particular problem were the scale and the concentration of Southern Cross care homes, which no single local authority could manage. Southern Cross was also a complex company with complicated models of finance which involved loan financing and equity financing.

29. The homecare sector is fundamentally different from the residential care sector. Care is carried out in a person’s own home and not in a care home. Therefore, homecare providers do not own or rent properties, except for their Head Office and, in the case of larger providers, any branches they have. Accordingly, homecare has an entirely different financial structure to residential care.

30. Also, unlike residential care, homecare is made up of many small homecare providers, with most having fewer than 100 people using their service.  

Each year, CQC approves approximately 500 new domiciliary care agencies.  

There is evidence that the homecare industry is becoming more consolidated, but the market still remains fragmented with a few large providers and many small ones.  

Laing & Buisson’s 2009 survey of the domiciliary care market found that 74% of homecare branches were stand-alone businesses and 26% were part of a business group. 10% of for-profit were part of a franchise group.

31. What the homecare sector needs is not an economic regulator to monitor its finances, but for councils to pay providers sustainable fees that reflect the true cost of service provision, including the real cost of regulatory changes, workforce development and a sustainable pay-rate that retains a skilled and qualified workforce. Economic regulation would add considerably to the costs of homecare providers.

32. We believe that, rather than monitoring the financial standing of homecare providers, the Government should require local authorities to have robust contingency plans in place to deal with a provider in financial trouble. This would ensure that continuity of care and quality of care were maintained.

33. The proposal that Monitor will become the sector regulator for adult social care causes us considerable concern:

— Monitor’s experience is of large organisations (orders of magnitude).

— It will be a blunt instrument, especially if it’s applied to all providers, not just those who wish to supply to the NHS as under any qualified provider.

— There is a risk of providers being disqualified because, although they are “for profit”, they are willing to operate at a very low margin because they provide a justifiable return on investment, employ local people and carry out a socially important function.


INTEGRATION OF HEALTH AND SOCIAL CARE SERVICES

34. UKHCA supports the closer integration of health and social care to better meet the needs of individuals and provide an enhanced patient/user experience. We believe that integrated services are necessary to meet the increasing demands of an ageing population, especially in this time of economic austerity.

35. Evidence suggests that some degree of integration already in place in a number of localities across England, but most PCT’s and local authorities have not moved as far as structural integration. According to a national survey of PCT chief executives and directors of adult social care, the main factors that promote integrated working are local determined. These include local leadership, vision strategy and commitment. Conversely, the top factors that hindered integrated working are nationally determined. These include performance regimes, funding pressures and financial complexity.61

36. The most cited example of successful integration of health and adult social care services is Torbay. Achievements there include reduced use of hospital beds, low rates of emergency admissions for those aged over 65 and minimal delayed transfers of care from hospital. Use of residential and nursing homes has fallen and at the same time there been a corresponding increase in the use of homecare services. There has also been increasing uptake of direct payments in social care and favourable ratings from the Care Quality Commission. However, it may be difficult to replicate the experience of Torbay as the area had some distinctive characteristics that will be difficult to reproduce elsewhere. In Torbay there was an urgent need to improve the council’s performance and the PCT was aware that more effective health care relied on improved social care. This meant that both the council and the PCT were receptive to change, and minimised any potential resistance to change.62

October 2011

Written evidence from National Pensioners Convention (SC 22)

SUMMARY

— The existing care system and its funding suffer from a number of inherent problems; namely its complexity, the unfairness of means-testing, a postcode lottery of costs and standards.

— The Dilnot Commission has recommended very little that will end means-testing, improve standards or prevent people from still having to sell their homes to pay for care.

— There are serious concerns over access to care services, as local authorities ration services either to those with the greatest needs or through additional charges. As a result, individuals will either be asked to pay more for services, go without or rely on informal carers for support. This in turn will place an increased burden on the individual and their family, without the provision of any additional financial or practical support.

— The personalisation of care must not be regarded simply as the introduction of individual budgets. Individual budgets raise serious concerns about suitability, safety and the protection of vulnerable individuals, as well as the emergence of third party organisations who will offer to manage budgets at the expense of care funding.

— The fairest and most equitable way of providing a universal, free at the point of delivery National Care Service that can offer comprehensive care to all in need, is through general taxation.

INTRODUCTION

1. For years the social care system has been failing the needs of those who are reliant on the service. At the heart of the problem are issues of complexity, the unfairness of means-testing, a postcode lottery of funding and charges and little support for family carers. In addition, there are concerns surrounding the standards and quality of care services, the training, remuneration and employment conditions of the care workforce and the lack of a robust and effective regulator. The system is therefore in urgent need of reform.

2. However, one of the major barriers to providing a comprehensive, joined-up service remains the artificial distinction between nursing care which is provided free at the point of delivery by the NHS, and personal or social care which is means-tested in the community. Today, frail elderly people are moved as quickly as possible from hospital into nursing homes, or they spend a long and stressful period at the end of their lives, paying a high cost for inadequate care in their own homes.

3. Not only has the division between nursing and personal care made the possibility of providing good quality, seamless support more difficult to achieve; it has also been responsible for incorrectly labelling illnesses such as dementia as social care and pushed services beyond the boundaries of the health service. Any inquiry into social care must therefore address this fundamental issue.


THE FUNDING OF SOCIAL CARE

4. On 4 July 2011, the Dilnot Commission into the future funding of care published its report entitled Fairer Care Funding. The Commission stated that the current care system was not fit for purpose and in need of urgent reform. It identified a number of fundamental problems:

- The current system is confusing, unfair and unsustainable.
- Eligibility for support varies depending on where you live.
- There is a lack of financial products to help people meet their care costs.

5. Alongside these findings, the Commission also made a number of recommendations, including:

- Capping an individual’s contribution to their care costs at £35,000. The state would then pay additional care costs once the individual had met that cap.
- Means-tested support for residential care would be available to those with assets/income worth between £14,250 and £100,000 (including the value of any property). For those with assets worth £75,000 the cost of care would be around £15,000. Those with less than £14,250 would not pay any care costs.
- Those in residential care would still be liable to pay for their food and accommodation costs—capped at a maximum of £10,000 per year. This would mean individuals paying up to £190 a week.
- The Commission’s proposals are estimated to cost £1.7 billion a year rising to £3.6 billion by 2026. The recommendations suggest that this money could be raised either through additional income tax, re-allocation of existing government expenditure or using a specific tax such as national insurance on those aged 65 and over.
- There should be a new national assessment system which would guarantee support to those with “substantial” needs or worse—but not anyone with moderate needs (including those requiring help getting in and out of bed). This assessment would be portable and apply if you moved from one area to another.

6. Despite the urgent need for a solution, the Dilnot Commission’s recommendations have fallen short of the expectations of older people, their families and carers. In particular:

- It remains unclear how the Commission’s proposals relate to care at home. At present the value of your property is not included in the assessment of your assets when determining if you are eligible for support from your local authority. The Commission is suggesting that this may need to change in the future. However, the report focuses almost exclusively on the costs and payment of residential care, and does not address those issues in relation to care at home.
- The proposal to raise the threshold on assets to £100,000 before being liable to pay care costs will not prevent older people from still having to sell their homes in order to pay for care. The Commission accepts that the median housing wealth for a single pensioner is £160,000, and therefore most home owners will be unaffected by the proposal.
- Introducing a cap on care costs of £35,000 amounts to just over one year’s worth of care in a nursing home. The Commission estimates that a year’s residential care costs £28,600. However, only a quarter of all over 65s are likely to ever need care that costs more than the capped amount. Given this, it is questionable whether the state would ever step in to pay any additional costs in all but a minority of cases. The Commission even states “We see our proposals as a type of social insurance policy, with a significant “excess” that people will need to fund themselves”.
- Suggesting that additional funding for care could be found by making older people pay national insurance places an unacceptable burden on a single generation—rather than sharing the cost of care across society as a whole. It would be the only area of welfare provision where one section of society was paying for itself eg older people paying for the care of older people, rather than the costs being shared across the population as a whole.
- Introducing a higher threshold of need before someone can access care will leave hundreds of thousands of vulnerable older people without any support in the community. Access to care services needs to be widened, rather than restricted in this way. The removal of low level support will inevitably lead to a worsening in conditions which will accelerate more severe care needs and higher costs.
- None of the proposals will end the means-testing of care, prevent people from selling their properties, assist family carers or address the urgent need to improve the standards and quality of care that individuals receive.

ACCESS TO CARE

7. In 2003, the Fair Access to Care Services (FACS) guidelines were introduced as a response to the outcry against the “postcode lottery” which allowed local authorities to use different criteria for assessing an individual’s need for care. The guidelines state that every local authority in England must use four standard criteria: critical, substantial, moderate and low to assess and deliver social care, but all the evidence shows that...
most councils now only help people with substantial or critical needs, leaving many needing help to fend for themselves or rely on friends and family for support.

8. It is estimated that at least 160,000 households are currently denied the help they need, whilst rising charges for those still receiving care in their own homes, are forcing older people to reduce or even stop their support services.

9. A National Coalition on Charging report\(^6\) in 2008 revealed that:
   - 80% of respondents who no longer use care services say charges contributed to their decision to stop their support.
   - 29% of respondents did not feel their essential expenditure (related to impairment/health condition) was taken into account in financial assessments to pay charges, meaning they have to choose between essential support and equally essential food, heating or utility bills.
   - nearly three quarters (72%) of people surveyed believe the government should think about the charges people pay for support at home in any plans to reform adult social care.
   - a fifth (22%) of people surveyed who currently use support suggested they would stop if charges increased further.

10. The Royal College of Nursing (RCN) has also claimed that the rationing of support to those with the most critical care needs has created a “revolving door”, as older people who have unmet care needs are forced to go to hospital, placing the NHS under greater strain. Nurses also say they are frustrated that when older people are admitted to hospital, for instance after suffering a fall, they are only able to give them “wash and go” treatment rather than being able to ensure they are eating well and able to live independently.\(^6\)

11. Given the government’s ongoing cuts to local government funding, and the lack of ring-fencing for social care, the rationing of services is therefore set to increase. Research suggests that at least 250,000 older people could lose their home care as a result.\(^5\)

12. Of these older people, 100,000 are projected to go without any support at all, while the remainder would be expected to buy support privately. There would be a 23% rise in unmet need, when measured in hours of personal care required but not provided (neither by paid or informal carers) and as a result there would be a 25% rise in hours of personal care provided by informal carers.

13. As a result of such rationing, those with low and moderate needs have no choice but to either rely on voluntary organisations or family members to help, or do without. Naturally, this situation can lead to a worsening of their condition and their needs may eventually reach a substantial or critical level. The cost of providing this extreme level of care is therefore more expensive in the long term than would have been the case with earlier intervention; when needs are at a lower level. Any solution must therefore be for the long-term.

14. However, what is extremely worrying is that because the social care system has long been the Cinderella service of the welfare state, it has encouraged low expectations from those who it is supposed to support. Many individuals have modest desires about what help they might get when entering the system. Many feel they are receiving less support than they need—or are trying to muddle through without any help or guidance.

15. The exclusion of lower bands of eligibility means that people have particular difficulty in getting support with practical—yet vitally important tasks—such as housework, gardening and shopping. The National Pensioners Convention’s own research has found the care gap can include a lack of help with cooking, gardening, housework, visiting day centres, going out, shopping, DIY/maintenance, adaptations to property (ramps, showers etc) and bathing.\(^6\)

16. Ultimately, the burden created by this care gap is felt by the individual’s family and carers. Despite a commitment from the previous government to “valuing” carers through a Carers’ Strategy which is due to come into force by 2018, there is no suggestion from the Coalition of changing the current rules on the carer’s allowance which prevents someone in receipt of a state pension from claiming. Many support services, such as respite care, are also unavailable to existing carers. As a result, the constant pressure of looking after a highly dependent individual, without the necessary support and help can lead to passive neglect, because the older carer is simply no longer able to cope.

**The Personalisation of Care**

17. The personalisation of care was at the heart of both the previous and present government’s policy, but the idea of personalisation must not be confused with the introduction of personal or individual budgets.

18. Local authorities are already facing an impossible task of delivering personalised care and support against a growing demand, with no extra funding, whilst at the same time trying to generate efficiency savings. Government policy and local authority practice, together with tightening budgets, therefore mean that the personalisation agenda is helping to produce a market-led model of care provision.

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\(^6\) RCN response to the Dilnot Care Commission, January 2011.

\(^5\) Personal Social Services Research Unit, LSE and University of Kent for Age UK, 2010.

\(^6\) Survey of social care users and providers, NPC, 2007. 

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\(^6\) Charging into Poverty, National Centre for Independent Living, 2008.
19. Local authorities increasingly outsource services to private and third sector providers; while under the direct payments scheme, an assessment is made of the user’s needs in terms of hours, and is converted into an amount required to deliver that care in the form of a personal budget which users can spend as they choose.

20. However, the introduction of individual budgets raises a number of serious concerns. Many budget holders will be met with a bewildering choice of care providers, consisting of local authority services, private companies and the voluntary sector. The individual will therefore need to be directed to the “experts” offering advice and services and will inevitably be drawn into the growing market where private companies, the voluntary sector and charities compete for contracts to supply such services. As a result, the organisation offering “advice” may be the same one that is also providing a service. This therefore raises serious concerns relating to impartiality and independence.

21. Research also shows the negative physical and psychological effects that the responsibility of managing individual budgets can have on older people. The IBSEN Individual Budget Pilots Evaluation report October 2008 showed that service outcomes for those using an individual budget in the pilot were not improved for older people, and that their psychological well-being was damaged.

22. However, despite this obvious drawback for older people, the government seems intent on promoting individual budgets as the only mechanism through which care services can be accessed. This “cash for care” model has shown that some local authorities are now refusing to offer a choice of how services can be accessed—with access to care being limited through direct payments only. The principle that all service users should have an individual budget in order to receive a minimal service is therefore inappropriate, especially as most frail older people simply want a decent service arranged for them that meets their needs.

23. Ultimately, the introduction of individual budgets will transfer risk and responsibility either to the individual who needs social care or to their relative(s). They must now take on management tasks or deal directly with the private companies which will provide their advice or care for profit. However, there is no clear guidance for the individual when becoming an employer.

24. Fundamentally, expecting some of our most vulnerable older people to take on the responsibility of micro-employers—recruiting, dealing with payroll matters, contracts, discipline, employment rights, paying tax and national insurance—is simply unrealistic. In effect, rather than giving choice, individual budgets open up opportunities for abuse by those who manage the individual’s affairs and those organisations who see it as a chance to win contracts and make profits. Already evidence is emerging around the country that private agencies are offering to manage budgets for an average cost of 10%-15%; which in most cases will be paid out of the money that should have been used on care. It should also be noted that at the moment, these brokers currently fall outside any regulatory framework.

25. In addition, individual budgets raise serious concerns about the safety and protection of vulnerable individuals who will be responsible for employing their own care workers, who as lone workers are at present also exempt from registration, regulation and inspection. The responsibility of individual budget holders for arranging suitable cover for staff absence due to sickness and maternity leave also adds to this concern.

26. Far from enabling a highly-skilled and motivated workforce, the model of provision that is actually emerging encourages low pay and poor conditions, and risks entrenching problems of inadequate recruitment, retention and career development.

27. Furthermore, shifting funding and responsibilities onto individuals undermines local authorities, local democracy and the role of the welfare state. The personalisation of care is therefore becoming synonymous with reducing choice, increasing privatisation and allowing the growth of an unregulated care service.

AN ALTERNATIVE VISION OF SOCIAL CARE

28. There is an urgent need to develop a proper and comprehensive social care system which addresses many of the problems and weaknesses associated with the current regime. This new system should include the following specific elements:

   — **National Assessment**—There should be nationally determined assessment criteria which will be used throughout England to assess care needs. Individuals should have the right to have their needs (critical, substantial, moderate and low) assessed and receive the appropriate care from a universal menu of services. At the same time family carers’ needs should also be assessed.

   — **A Comprehensive Service**—Individuals and their family carers should be entitled to receive a variety of care services from a range of regulated providers, which will be of the highest standard. There should no longer be a divide between health and social care provision and the process of accessing care will be transparent and easily understood. All services will operate to nationally agreed standards which will be properly regulated and enforced.
— **Information and advice**—Individuals and their carers should be able to easily access straightforward information and advice about their entitlements to services at every stage of their care, and advocacy when required. Whether in the community, care home or hospital, individuals and their family carers should be entitled to receive information which clearly explains their entitlements to care, how to access the services available and their rights as a service user.

— **Personalised care**—There should be a range of care and support services made available that can be tailored to individual personal circumstances and needs. Care and support should be designed and delivered around an individual’s needs through a regulated provider, whilst the responsibility for managing budgets should lie with the local authority or NHS.

— **Fair funding**—Society should share the cost of providing care for those in need. A tax-funded universal National Care Service would entitle individuals to free non-means-tested care, support and accommodation appropriate to their needs.

October 2011

**Written evidence from the Royal College of Physicians (SC 23)**

**SUMMARY**

**A. Coordination in Health and Social Care**

— The RCP advocates an integrated model of care in which traditional professional boundaries are broken down so that health professionals can manage patients using integrated care pathways designed by local clinicians.

— Successful multi-professional team working is essential to an effective modern healthcare system and to the management of individuals' medical conditions.

**B. Barriers to Integrated Care**

— Separation between social and health care presents a barrier to continuity of care.

— The RCP recommends that Health and Wellbeing Boards (HWBs) embed secondary care physicians in their structures and establish robust mechanisms for obtaining clinical advice and input.

— To support the development and dissemination of good healthcare practice in care homes, there needs to be multi-agency and multi-professional national leadership, with greater physician involvement.

— The current tariff and payment structures reward episodic and disconnected care. The RCP believes that the needs of older people would be better met if there were a tariff structure that better reflected clinical complexity.

— The current informatics structure undermines the vision of patient choice and an outcomes-based health service. The RCP recommends an information system that gathers standardised person-level data and develops a single person-level record.

**C. Challenges Facing the Acute Sector**

— In the acute sector, poor service management and design introduces a number of barriers to the provision of appropriate, high quality care centred around the needs of the patient.

— The balance between specialism and generalism in acute settings is crucial if we are to meet the demographic challenges facing the health service and deliver the best quality care for patients.

— Patients, including older people, are not getting the care they deserve at night, weekends and bank holidays. The RCP recommends that any hospital admitting acutely ill patients should have a daily visit from a consultant.

— There must be a more integrated regulatory approach to cooperation, choice, quality and safety. Both Monitor and the CQC must also increase clinical involvement in their structures.

— The RCP also urges the government to plan for the recommendations from the current Francis Inquiry to be embedded in the regulatory process.

**D. Shared Decision Making**

— Personal *health* budgets are one tool amongst many and—whilst there may be a limited set of circumstances in which they are a useful, welcome tool—there will be many occasions when they are *not* the most appropriate approach.

**A. Coordination in Health Services and Social Care**

1. Good care needs to see the patient and their experience in the context of their lives, social support, relationships, cultural experience, gender and a range of other factors. Supporting care for individuals, including older people, is a wider societal issue. The provision of services should support people as long as possible in
their own homes. Living productive independent lives, requires close integration between health services, social care and the voluntary sector, recognising that most support to older people is given by family and friends.

2. **The RCP advocates an integrated model of care, where traditional professional boundaries are broken down so health professionals can manage patients using integrated care pathways designed by local clinicians.** This approach is set out in *Teams without walls*, a joint RCP, Royal College of General Practitioners and Royal College of Paediatrics and Child Health publication, that includes existing examples of integrated care. *Teams without walls* identifies a number of key components in the provision of integrated care:
   - Population health needs and inequalities are considered at the planning stage.
   - Communication and service gaps are identified. Patient involvement is an essential part of this.
   - The service knowledge of local clinicians and public health data are essential.
   - Clinical leadership is required for successful commissioning— involving both generalists and specialists.
   - Regulators should inspect for improvement based on care pathways, as well as regulating organisations.
   - Commissioning must:
     (a) commission pathways, delivered by teams, working in networks;
     (b) promote partnerships, leadership and enthusiasm in its local clinicians;
     (c) set boundaries, support clinical innovation and monitor its effectiveness;
     (d) use evidence that is valid, reliable and reproducible; and
     (e) ensure that local clinicians are enabled by its process and not hindered or inhibited by it.

3. **Successful multi-professional team working is essential to an effective modern healthcare system and to the management of individuals’ medical conditions.** This is particularly true for older people with long-term conditions. This includes holistic plans for diagnosis, treatment, rehabilitation, support and long term follow up. Failure in communications between healthcare professionals has a negative effect on the communication between staff and patients, relatives and carers.

4. Good liaison between GPs, specialist physicians and social care professionals in the management of patients is essential if their needs are to be met. Integrated working allows patients and their carers to benefit from specialist knowledge (including early referral for more specialist opinions and diagnostic tests when needed), the general care provided by GPs and primary care teams, and the help and support provided by those working in social care. An integrated social and clinical approach should support anticipatory care planning, including preferred place of care and end of life plans.

5. As highlighted in *Teams without walls*: "the use of patient pathways (some of which need to be developed and others adapted to local circumstances) as the building blocks for services is recommended, with the right balance between prevention, early identification, assessment, intervention and, when necessary, long-term support. This will have implications for commissioners, providers and regulators of services."

6. The RCP agrees that the system of funding for social care needs to be reformed so that it is fair and affordable. We support further exploration of the recommendations made by the Dilnot Inquiry.

A.1 **Strategic engagement and coordination**

7. *The separation between social and health care presents a barrier to continuity of care.* The arrangements for discharge and access to social care support must be improved. Delays in discharge from hospitals, sometimes pejoratively called “bed blocking”, with negative impact on dignity and outcomes, remains an all too common phenomenon. Innovative approaches, such as the shared budgeting approach being explored in Torbay should be encouraged, evaluated and disseminated.

8. If we are to achieve more integrated health and social care services, it will be crucial that the proposed new healthcare commissioning arrangements fully involve a range of health and social care professionals. Clinical Commissioning Groups (CCGs) must build strong working links with Health and Wellbeing Boards (HWBs). The NHS Commissioning Board (NHS CB) should assess the extent to which CCGs have collaborated with other professionals and integrated primary, secondary and social care and public health in their annual assessment. Strong professional networks should be established and developed to further enable a wider range of specialists to feed into commissioning decisions. A network of the appropriate specialists should always be involved in commissioning decisions that affects the services they provide.

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9. Local authority-led HWBs will play an important role in coordinating health and social care services. The RCP recommends that HWBs embed secondary care physicians in their structures and establish robust mechanisms for obtaining clinical advice and input. Secondary care specialists—together with public health experts, social care professionals, GPs and lay representatives—must be involved when assessing needs via the Joint Strategic Needs Assessments, and when setting priorities via the Health and Wellbeing Strategy. Likewise, establishing links between local HWBs and any emerging clinical networks and clinical senates could be an important step.

10. Patients should be empowered and enabled to be involved fully in commissioning decisions of both CCGs and the NHS CB.

A.2 Care in appropriate settings

11. The RCP believes that everyone has the right to appropriate care in appropriate settings. The focus on exploring opportunities to offer care “closer to home” in community settings and delivering care in innovative ways in order to better meet patients’ needs and wishes is welcomed. However, older people must have ready access to care in acute settings when necessary.

12. Similarly, the RCP has identified that discharge summaries provided when a patient leaves hospital need to be improved—the new Department of Health discharge toolkit is based on our work done by the RCP’s Health Informatics Unit.

13. Acutely ill older people are often poorly serviced by lack of speedy access to appropriate assessment/treatment (with or without direct geriatrician involvement), multiple transfers of care, and lack of skills in the general medical needs of older people in medical admissions units and other services. The gatekeeper function of the GP needs to be re-examined, to look at the reasons why referrals have been delayed when it would be appropriate to do so, or when diagnosis and care could be better given in the community (perhaps with additional support).

14. The PANICOA (Preventing Abuse and Neglect in Institutional Care of Older Adults) report highlighted “almost unanimous view expressed by all staff that the acute hospital is not the ‘right place’ for older people.” The study concluded that “the prevalence of this view results in the physical environment, staff skills and education and the organisational processes acting as barriers to delivering dignified care to older people”. If staff do not think older people should be in hospital, then care suffers. Older people often need to be in hospital if they need access to specialist care, investigations and management.

15. Hospitals have not been designed to meet the needs of frail older patients or patients with dementia. Therefore the care setting itself is often not conducive to the provision of dignified care. The PANICOA study describes acute hospital wards as “confusing and inaccessible” and says that they are “not fit for purpose” as a place to treat those over 65. This needs to change, so that older people are treated appropriately in hospital when they need to be there and staff attitudes need to change to accept that older people need hospital care when appropriate. However, more care can also be given in community settings to avoid hospital admissions.

16. People with complex health and social care often need a key worker who can help them navigate through their health and social care provision.

A.3 Doctors and care homes

17. There needs to be multi-agency and multi-professional national leadership, with greater physician involvement, to support the development and dissemination of good healthcare practice in care homes. Action is also needed to address the unacceptable level of medication errors in care homes. The Royal College of Physicians, National Care Forum (on behalf of the Care Provider Alliance), the Royal College of General Practitioners, the Royal College of Psychiatrists, the Royal Pharmaceutical Society, the Royal College of Nursing, the Health Foundation and Age UK are currently exploring this issue. The project, Working together to develop practical solutions: An integrated approach to medication safety in care homes, aims to develop thinking around: how health care clinicians can support staff in the care home setting to reduce the incidence of errors and near misses; and how to treat and care for people living in care homes to ensure that they are protected from harm.

The aim of the project jointly to develop a set of practical tools to help residents, doctors, pharmacists and nurses to provide safer care and reduce the incidence of medication errors and near misses in care homes.

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B. BARRIERS TO INTEGRATED CARE

B.1 Tariff structure

18. The current tariff and payment structures reward episodic and disconnected care. The incentives/disincentives of Payment by Results need to be re-balanced to bring integrated specialist and generalist care closer to the patient’s home. In the current system it is often financially easier to admit the patient rather than manage them outside hospital or to commission separate specialist services in primary care, thus avoiding the full tariff price of a consultant-delivered service in an outpatient clinic.73

19. The RCP believes that the needs of older people would be better met if we moved to a tariff structure that better reflected clinical complexity. In order to encourage integrated working, consideration should be given to moving towards a system in which payments are received, not for single episodes of care, but over the longer term (eg annually or by pathway), thus encouraging the prevention of readmissions, etc. Teams without Walls offers a simple way of dealing with this issue “by designing, commissioning and paying for new, cost-effective, service pathways which are beneficial to the patient... [The Department of Health] could explore the concept of payment by pathway (PbP) for an episode of care, and annual payment by condition (a PbC) for long-term conditions.”74

B.2 Data and information

20. The current informatics structure undermines the vision of patient choice and an outcomes-based health service and acts as a barrier to the provision of joined up services across health and social care settings. The RCP’s Health Informatics Unit has identified the following key issues with current health information and data structures:

   (a) Disparate recording systems and reporting methods for different clinical specialities and hospital departments (eg separate recording systems for diabetes, cancer, etc). This acts as a disincentive to holistic care.

   (b) Managerial targets have focussed attention at an institutional level, where performance has traditionally been judged. This has built barriers across primary, secondary and social care, providers and even departments. This in turn makes data sharing, integrated analysis and the management of patients across care settings difficult.

   (c) Concerns about the validity of individual patient data collected by the main record level databases, especially from the clinical perspective. These databases—Hospital Episode Statistics (HES) and the Patient Episode Database Wales (PEDW)—were originally designed to monitor activity and health trends across the service, and to allocate resources. As such, they are most effective when analysed at an aggregate, national level, rather assist with the management of patients.

   (d) Information on patient experience, where collected, is usually subject to separate information gathering exercise (eg questionnaires, etc). This makes it difficult to build a holistic, integrated and ongoing picture of the care patients receive, balanced against clinical outcomes.

21. The RCP recommends that we move to an information system that:

   (a) gathers standardised person-level data and develops a single person-level record;

   (b) embeds clinical standards into data collection and quality indicators;

   (c) revises requirements for data collection so that they focus on clinically valuable information and the basic building block of health care—the patient-professional interaction;

   (d) “mainstreams” the collection of information on patient experience and perspectives;

   (e) synchronises records and enable data sharing, comparison and integration across providers, boundaries and specialties; and

   (f) universal introduction of standards for structure and content of records.

22. The integration of information about health and social care services would be of benefit not only to patients and carers, but also to commissioners and service planners, including HWBs.

B.3 Reconfiguration

23. There is evidence that the consolidation of specialist services can bring better quality—this is usefully outlined in the recent King’s Fund report on the topic,75 to which the RCP contributed. Although issues surrounding reconfiguration are complex, it can also be argued that having a wide range of services on-site helps with managing the increasing levels of co-morbidities faced by a growing elderly population.

C. Challenges Facing the Acute Sector

24. We face rising levels of medical admissions and chronic disease, an ageing population and, as a result, increasing numbers of patients presenting with multiple conditions and a background of frailty and dementia. The service must adapt if we are to meet the challenge of providing holistic care for patients, including older patients, with co-morbidities and complex needs. In the acute sector, poor service management and design introduce a number of barriers to the provision of appropriate, high quality care centred around the needs of the patient. Existing evidence has repeatedly shown that the following must be in place if we are to deliver high quality care that meets the needs of older patients:

(a) Adequate staffing numbers, with sufficient time available to care for patients, including those with complex needs (e.g., dementia, frailty, and communication difficulties).

(b) Appropriate education and training so that we have a workforce with the right skills to deal with the current (and future) case mix.

(c) Better continuity of management of patients whilst in acute settings and across providers, with clear lines of accountability and better communication between staff, and improved flows of information across the system.

(d) Improved communication with patients, their relatives and carers, and better involvement in decisions about treatment and care, with care received in appropriate settings. This includes communication on difficult issues such as dementia, dying, and disability.

C.1 Generalism in the acute sector

25. Acute hospitals need a workforce appropriately trained to deal with the acute medical intake and aftercare of these patients. The balance between specialism and generalism in acute settings is crucial if we are to meet the demographic challenges facing the health service and deliver the best quality care for patients. This means looking at who is best placed to look after the increasing number of complex patients who do not neatly fit within a single speciality. Assessments need to be done by someone with the requisite skills to work through a diagnostic process and judge which is the most important problem to be managed, and with what level of priority. This is important because there may be conflicts between best treatment options for all the conditions. Staff also need to be skilled in discharge procedures and liaison with social care.

C.2 Organisation of care in acute settings

26. The RCP is concerned with the mounting evidence showing that poor care is delivered to patients in hospital during out-of-hours periods. Currently too often too many junior doctors are covering too many ill patients with too few senior staff in attendance during out of hours periods. This results, at worst, in inadequate senior cover during the weekend and on bank holidays, leading to a higher mortality rate and more errors in care in hospitals at these times. At best, the result is a poor experience for patients who are required to meet the schedule of healthcare professionals, rather than being able to access services and care at a time that meets their needs. Patients, including older people, are not getting the care they deserve at night, weekends and bank holidays. In December 2010, the RCP released a statement on out-of-hours hospital care and the need for increased consultant cover. We recommend that any hospital admitting acutely ill patients should have on-site supervision by a consultant throughout the day. Hospitals need to increase the availability of senior doctors in acute admissions units, particularly at weekends.

27. In response to these issues, the RCP is developing a range of practical toolkits aimed at physicians and designed to improve the clinical management of the acutely ill patient (for more information see: http://www.rcplondon.ac.uk/resources/professionalism/acute-care-toolkit). This range of acute care toolkits include specific guides on:

(a) handover;

(b) delivering high quality care throughout the admission pathway; and

(c) the acute frail elderly and interventions to minimise conversion from acute medical unit admission to prolonged hospital stay.

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C.3 Regulation

28. The RCP has been calling for a more integrated regulatory approach to cooperation, choice, quality and safety. The processes and approaches of Monitor and the Care Quality Commission (CQC) must be harmonised and streamlined. Although economics and patient safety must be robustly assessed against independent frameworks, with independent recommendations, CQC and Monitor should work together to ensure that trusts have a single direction of travel, in which patient safety and economics are better reconciled. The RCP would also urge the government to plan for the eventual recommendations from the current Francis Inquiry to be embedded in the regulatory process.

29. Regulation needs to be able to look across institutions and consider care pathways. Health regulation needs to be better joined up with local authority scrutiny processes.

30. Both Monitor and the CQC must also increase the amount of clinical involvement in their structures.

D. Shared Decision Making

31. Supported self care is an important component of integrated care. In order to make this a reality, patients “will need help to understand the system, how to self manage and how to use services appropriately”. The RCP agrees that there should be a greater personalisation of services and access to services. We stress that the personalisation of services is not dependent on giving patients’ and/or carers’ budgetary control—choice can be enabled through effective dialogue between patient and physician, against a backdrop of specialist and patient involvement in commissioning. Personal health budgets are one tool amongst many and—whilst there may be a limited set of circumstances in which they are a useful, welcome tool—there will be many occasions when they are not the most appropriate approach. The risks associated with personal health budgets—for example, service fragmentation—will need to be fully considered. We also urge an honest appraisal of personal care budgets where they are currently used, ensuring that we guard against replicating these in relation to health. Patients’ and carers’ desire for adopt personal health budgets, and associated administration, will also need to be fully considered.

October 2011

Written evidence from Hampshire County Council (SC 25)

Executive Summary

— This submission from Hampshire County Council presents evidence that we have gathered during our Commission of Inquiry into Personalisation, and subsequently, which we hope will assist the Committee in its deliberations on this important matter, and in making its recommendations to the Government prior to the publication of the Social Care White Paper.

— Hampshire County Council welcomes the opportunity, following the publication of the reports of the Commission on Funding of Care and Support (Dilnot Commission) and the Law Commission, to engage in wide public debate on these issues, and agrees that we need to work towards a system that is equitable and transparent for all. However any reform needs to be properly funded, and we would urge the Government to play its part by providing its share of the additional resources needed for social care.

— We also highlight the need for any reform to be consistent with the principles of localism, giving the local authority the freedom to address local concerns, and ensure services and policies are responsive to the needs of the people of Hampshire.

— Any reform also needs to take into account the whole social care system, including early intervention and prevention, crisis care and long term care and support, both residential and non-residential. We consider that the Dilnot Commission focussed too narrowly on residential care.

— Hampshire County Council supports many of the proposals put forward by the Dilnot Commission, particularly the principle of a partnership between the state and the individual in paying for the costs of long-term care, and the proposal for raising the capital threshold. Many of the recommendations of the Dilnot Commission support those made by our own Commission of Inquiry into Personalisation.

— However, Hampshire County Council has concerns about the affordability of implementing the recommendations, particularly the recommendation on the capping of social care costs, in the context of the already very significant pressures on local authority budgets. These pressures are due both to substantial reductions in grant funding, and increasing demographic pressures and increasing complexity of needs. We have undertaken financial analysis of the likely costs to Hampshire of implementing the Dilnot Commission’s recommendations, which would indicate that the Commission significantly underestimated the costs. Moreover, increased costs would fall disproportionately on those authorities where there are greater numbers of self-funders.

Hampshire County Council is supportive of the implementation of the recommendations of the Law Commission, and considers that the development of a single statute for Adult Social Care which supports the principles of personalisation should be a priority for the Government.

1. INTRODUCTION AND BACKGROUND

1.1 In 2008 the County Council initiated a consultative, cross-party Commission of Inquiry into Personalisation to consider the future of adult social care and the transformation of care services. Commissioners included national figures, academics, politicians, journalists and experts in the social care field. The Commission held four public hearings, a BBC-style Question Time debate, attended all three political party conferences and took evidence from over 150 people, including service users, and 36 organisations. The Commission’s final report, “Getting Personal: a fair deal for better care and support” was published in November 2008. The Commission made wide-ranging recommendations based on the evidence it collected, some of which the County Council has already implemented, and some of which were directed at central government. The recommendations of the Commission were costed at £15 to £22 million for Hampshire and £750 to £1,100 million nationally. Many of the Commission’s recommendations are supported by the findings of the Law Commission and Dilnot Commission: the commonalities are discussed below. We hope that the recommendations of our Commission will be taken into account and used as supporting evidence in the development of the forthcoming White Paper. For full details of the Hampshire Commission please see http://www3.hants.gov.uk/adult-services/commission-personalisation-homepage.htm.

1.2 The recommendations of our Commission were used to inform the development of Hampshire’s vision for personalised social care services, with a strong focus on choice and control for individual service users and taking account of issues of diversity and equality. We also aim to build resilient communities through a culture of participation, so that people can look outwards to their communities for support. To achieve this we set out a clear offer of three levels of adult social care. The first is a universal level, with the provision of universal services to the wider community to help prevent or delay the need for more targeted social care interventions. This includes the delivery of information, advice and assistance to people who have not had or do not want an assessment, or who are not eligible for services. The second level is targeted social care services for those who need immediate safeguarding from abuse, people in crisis and for carers, provided following an assessment but not means tested. The third level is targeted services, following a community care assessment and a financial means test and will include long term support. Any proposed reform must take into account this whole range of social care services, as well as the benefits system, to avoid a narrow focus on short term investment. Reform must allow for innovation locally and for local authorities to shape services around the needs of local people.

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**Care and Support – model**

**Community Safety**

**Early Intervention Prevention Services**

Via Grant funding and Commissioned e.g. CIT OPAL Community Development

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**Safeguarding**

**Crisis Care and Re-ablement**

Via Commissioned menu of services (including In House provision) e.g. Time to Think Welcome Home CRT

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**Empowerment**

**Long Term Support**

Individual personal budgets – spot purchasing Personalised support plans

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**Universal Offer**

Maximising Independence

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**Targeted**

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2. FUNDING OF ADULT SOCIAL CARE

2.1 Hampshire County Council supports the broad view of the Dilnot Commission that funding for social care should be a partnership between the state and the individual. Hampshire’s Commission found that many people find the current system unfair, and that it provides a disincentive to saving. Our specific responses to the Dilnot Commission’s recommendations on funding are as follows:

2.2 We believe that the introduction of a cap on care costs would help people to plan for the costs of their care, and stimulate the development of the market for suitable financial products to help people achieve this. The financial services industry’s investment in marketing these products would also help raise public awareness of the need to plan for future care needs.

2.3 We believe that planning for social care needs in older age is inextricably linked to planning for older age in general and that therefore, in the longer term, financial planning needs to be linked to personal pension provision. Given that many people fail to make adequate provision for their income in older age despite the fact that most people can expect to reach retirement age (while only about a quarter will need to spend a substantial amount on care), we remain of the view that some form of compulsory scheme is required. Such a scheme would need to provide a flexible range of options about how and when people contributed to it. A link with pension provision could well encourage long-term planning and thus improve affordability. For people of working age, a range of solutions could be devised, for example, allowing the purchase of care insurance as part of a pension scheme, or enabling people to commute part of their pension lump sum to buy a care annuity. With the introduction of automatic enrolment into workplace pensions due to be introduced in 2012, the government could look at potential links to that scheme and also how saving for care costs could be incentivised through the tax system.

2.4 We also consider that access to independent financial advice is a key priority as most people enter long term care without accessing such advice: the County Council is already working to set up a panel of independent financial advisers to enable self-funders to make appropriate decisions about their care.

2.5 Our main concern regarding the introduction of a cap on care costs is affordability (see 2.12 below), though there may be a balance between “fairness” and affordability in setting the level of the cap. We also have concerns about the number of people who may be brought unnecessarily into the care system. This is because a cap may provide a disincentive to the provision of unpaid care, as people may feel entitled to “formal” care if they have met the cost of their care up to the cap. Moreover, people who would otherwise have funded their own care and who may never reach the cap will enter the system through requiring assessments and tracking of their care. The local authority may also be subject to increased requests for assessments from those who do not meet eligibility criteria. The cost and administrative burden for local authorities of these additional assessments and tracking people’s notional spend up to the cap would also be substantial. There would be significant one-off costs of assessments when the new system is introduced, which would have to be factored into costs and timescales.

2.6 The Dilnot Commission did not take into account the impact of its recommendations on the market, particularly for residential care for older people. Local authorities currently provide value for money for the taxpayer by achieving significant economies of scale in purchasing residential care. A cap on contributions would reduce the length of time self-funders are in the market, meaning more people in residential care would be funded by the local authority. This will create a situation where the local authority is the monopoly buyer which would not be conducive to sustainability or competition in the private market. Moreover, people who had not yet reached the cap would expect to be able to purchase care at a price comparable to the local authority, as this amount would be counted towards the cap. If the market is to remain sustainable, local authority rates will have to increase, meaning the cost of taxpayer funded care will increase.

2.7 The additional costs of implementing the cap would be disproportionately high for authorities where there are many self funders, like Hampshire (research has indicated that rates of self-funders in Hampshire are 57% for residential care and 64% for home care). Costs of care also vary across the country and in Hampshire people would reach their cap and require local authority funding more rapidly than in other areas.

2.8 We agree that the means test should be retained to protect those who have eligible care needs but who cannot afford to make their personal contribution. We agree that the capital threshold is too low and should be increased (the Hampshire Commission recommended raising the threshold to £50k). However our Commission recommended that the means test should be common across all types of care, applying to home care as well as residential care, which could be facilitated through extending the deferred payments scheme. Specifying financial assessments for residential care that are not applicable for supporting people at home runs counter to the desire to maintain people in their own homes. Again, there may be a balance between fairness and affordability to be found by setting the threshold at a lower level than recommended by the Dilnot Commission. There needs to be a transparent means for deciding how the level of both the cap and capital threshold should be reviewed annually.

2.9 We agree that younger adults with care and support needs cannot be expected to have planned in the same way as older people, and therefore that those born with care needs or who develop them as younger adults should receive greater funding. However clarification would be needed on the treatment of compensation...
awards for personal injury, which currently make provision for future care costs, in order that the public is not asked to pay for this care through taxation as well as through their insurance premiums.

2.10 We strongly support the Dilnot Commission’s recommendation that benefits be aligned with eligibility. In the context of commitment to expand direct payments for social care and offer personal health budgets, alongside current welfare reform, it would be helpful if social care funding and benefits could be looked at together. We strongly advocate changes that recognise the need to provide better financial support for carers. Our Commission drew attention to the effects of loss of earnings during working age that carers face, which can leave them at risk of poverty after the age of 65, particularly since older carers cannot currently claim the full Carers Allowance as well as their State Pension. There is an implicit assumption built into the system that people over 65 do not provide care, which is not supported by the evidence. It is also contrary to the trend towards more flexible retirement ages and people working longer.

2.11 We agree that people should contribute a standard amount towards their hotel costs, as they would be expected to do if they were receiving care at home. However under the current system people do contribute what they can afford, less their Personal Expense Allowance. Charging hotel costs to those in NHS funded care could also be considered, which may generate income that could be used to fund the additional costs of implementing social care reform.

2.12 We have undertaken financial modelling of those of the Dilnot Commission’s recommendations which would impact on local authority budgets, shown in the table below. We have based this on a cap of £35k and hotel costs of £10k per annum. We have applied the raising of the capital threshold to those receiving non-residential as well as residential care. The cost of assessments includes additional assessments for carers (though assumes only 10% take this up). Excluded from the estimate are any consideration of the costs for extending the deferred payments system, and the cost of tracking the notional care costs incurred by self-funders up to the cap. The lower estimate assumes no change in current unit costs for residential care, while the upper assumes an increase in unit costs as a result of the impact of the cap on the market (see 2.6 above). The estimated additional costs to Hampshire County Council are therefore in the range £65.8 million to £106.5 million, with one-off costs of £11.6 million. This should be seen in the context of an Adult Services departmental budget of £310 million.

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<tr>
<td>Total potential additional costs:</td>
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<tr>
<td>Additional assessments                      1,164,000</td>
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<tr>
<td>Maximum potential lost income for under 65s        7,607,000</td>
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<td>Additional HCC costs for OP self-funders           50,273,979</td>
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<td>Increasing the threshold from £23,250 to £100,000:  6,755,697</td>
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<td><strong>Total potential additional costs, with addition of potential impact on the market:</strong></td>
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<tr>
<td>Additional assessments                      1,164,000</td>
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<td>Maximum potential lost income for under 65s        7,607,000</td>
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<tr>
<td>Additional HCC costs for OP self-funders           69,752,125</td>
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<td>Increasing the threshold from £23,250 to £100,000:  6,900,307</td>
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<td>Increased costs for current clients               21,044,400</td>
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<tr>
<td><strong>One-off costs of additional assessments</strong>        11,640,000</td>
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<tr>
<td><strong>Total potential additional costs</strong>               106,467,832</td>
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2.13 These estimates show costs well in excess of those estimated by the Dilnot Commission. Hampshire usually accounts for approximately 2% of social care funding. The Commission estimated additional costs nationally of £1.7 billion in 2010–11, of which Hampshire’s allocation would be only £34 million. Any reform would need to allocate funding on the basis of not disadvantaging those authorities with large populations of self-funders.

2.14 Hampshire County Council has also undertaken detailed forecasting of the likely increase in numbers of care packages and unit costs due to demographic and complexity factors in the period 2011–12 to 2015–16 based on population forecasts and Adult Services past trend data. Care package numbers are forecast to increase by 10% in this period, and these increases, combined with an increase in average weekly costs of care packages, are forecast to cost on average an additional £10.5 million per annum. While the demographic assumptions made by the Dilnot Commission are broadly in agreement with our own, the assumption that unit costs will rise in line with GDP may not take into account increasing complexity of needs. Local authorities are expected to meet these costs in the context of cuts in funding, and therefore the additional cost of any reform to the system is likely to be unaffordable for local authorities and must therefore be properly funded by government.

3. ADULT SOCIAL CARE LAW REFORM

3.1 Hampshire County Council welcomes the recommendations of the Law Commission, and considers that its report comprehensively sums up the practical and policy considerations relating to its recommendations.
3.2 In addition to the main recommendation of bringing Adult Social Care law into a single statute which would support the development of personalisation, we would particularly welcome:

— The new duty to assess carers (Hampshire already offers a range of services for carers, including assessments and a “take a break” voucher scheme, and has recently set up a Carers Partnership);

— The duties and powers to safeguard adults from abuse or neglect (Hampshire is already implementing the Law Commission recommendations on safeguarding, leading the Hampshire Safeguarding Adults Board. We also have robust Quality and Contract Monitoring processes in place, and work collaboratively with CQC); and

— The duty to offer information, advice and guidance (we have developed and promoted our Care Choice website, fund a range of advice services, signpost via our contact centre, and are developing a Village Agents model for signposting in rural areas). Although the Dilnot Commission recommended a national awareness campaign, we consider that information is best provided on a local basis.

3.3 We would additionally welcome clarity in relation to:

— The duty of the local authority in promoting quality in care settings even when it does not directly commission care from that provider;

— The duties and powers of the local authority in the event of provider failure;

— The processes relating to NHS continuing care; and

— The link between direct payments to carers and the provision of respite care.

4. Variation in Access to and Charges for Social Care in England, and the Barriers Faced by Recipients of Health and Social Care when they wish to Relocate to Another Area

4.1 Hampshire’s Commission acknowledged that people in different authorities face differing allocation and charging regimes and we found deep unhappiness at the perceived unfairness of the system and the lack of portability of entitlement. A more nationally consistent approach to assessment with scope for local variation in service commissioning that takes into account local areas and markets would be much more equitable.

4.2 In response to its findings, our Commission recommended that eligibility criteria be standardised nationally, and set at Substantial and Critical. This recommendation was supported by the Dilnot Commission. We consider that people with Low or Moderate needs can be helped most cost effectively through early intervention and prevention services, universal services which do not carry the cost of assessment processes.

4.3 We recognise that for some portability of assessments is an issue. However local authorities cannot be expected to provide exactly the same care package, because different services exist in different areas. Our experience suggests that this affects a relatively small number of people (in the last year, in Hampshire, only 141 clients (0.7% of service users across all care groups) were recorded as moving out of county). The number of complaints we receive about portability is very small, and tend to relate to charging, adaptations, and the availability of particular care options rather than the assessment. Therefore the response needs to be proportionate to the scale of the problem, as creating a national assessment regime may have unintended consequences. We would suggest that an ADASS protocol whereby authorities agreed to accept each other’s assessments may resolve the problem, without creating a national care system.

4.4 In line with the principles of localism, we would wish local authorities to retain discretion in setting their own contributions policies and commissioning services which are responsive to local needs. The voluntary and community sector plays a vital role in delivering services, but varies considerably between areas. Local authorities therefore need the freedom to work with local organisations to shape services. For these reasons it would be difficult to establish a Resource Allocation System that would be applicable nationally. Any attempts to standardise the assessment process would need to avoid being prescriptive and take into account professional judgement and allow discretion to account for people’s individual circumstances.

4.5 Currently Ordinary Residence presents barriers to moving to community-based living arrangements, particularly for people with learning disabilities, as the deregistration of residential homes can lead to significant financial liabilities for local authorities if there are clients placed from out-of-county. It would be helpful if this could be addressed at a national level.

4.6 With several universities in Hampshire which have been successful in attracting increasing numbers of students with disabilities, we would also welcome clarity on the relative responsibilities of the university and the local authority in meeting the future needs of students with disabilities.

5. Personalisation

5.1 We strongly support a focus on personalisation and personal budgets in any new funding system. A person-centric system that works with individuals to determine their support is essential.
5.2 Hampshire is working to develop new models of care which support personalisation and promote greater independence, wellbeing and choice for older people. We have already provided 240 units of new-build Extra-Care Housing since 2007 and are committed to stimulating the market to provide additional capacity. Extra-Care Housing is associated with better health outcomes for individuals, enabling them to access safe, secure and appropriate housing. It also provides a model of care which allows couples to remain together, and increases financial autonomy and flexibility for older people. Extra-Care also has benefits for the wider housing market, releasing family housing (social and privately owned) back into the market, which will also enable it to be modernised. Crucially, Extra-Care is also more cost effective than high cost residential care, thereby generating savings for the local authority. It is vital that national policy on social care, housing and benefits supports this development.

5.3 We would welcome a greater focus on personalisation in residential homes, which would also help improve quality. The Law Commission recommended offering direct payments for residential care. We consider that it is unlikely that individuals would be able to achieve the same economies of scale as the local authority in purchasing residential care; however younger adults in residential care would benefit from being able to access direct payments to purchase day care. It may be that increased focus on personalisation in residential homes could be achieved through CQC standards requiring service user and community involvement in homes.

5.4 Service user and carer involvement in the development of services is of critical importance in relation to delivering successful outcomes and in Hampshire we are working towards models of “co-production”, working to support the development of user led initiatives and ensuring engagement in planning. However it must be recognised that co-production has both time and resource implications, with pressure on social care budgets mitigating against models of co-production.

5.5 Research by Skills for Care published in 2011 indicated that the number of jobs in adult social care is projected to grow by between 24% and 82% between 2010 and 2025, which means there could be 2.1 to 3.1 million jobs by 2025. There is therefore an urgent need to develop additional capacity across the workforce, attract those from non-traditional backgrounds, and ensure staff have the skills to meet increasingly complex needs. This will mean workforce planning to ensure the right skills mix, and an investment in staff training, as staff are vital to delivering personalised, quality care.

6. Economic Regulation of the Social Care System

6.1 We consider that some market regulation is required to ensure that large care providers have structures in place whereby management teams are in touch with the quality and safety of provision and have financial governance and ownership structures that don’t put vulnerable residents at risk. This cannot be left to local authorities as large providers operate across local authority boundaries.

6.2 We would welcome clarification of the extent of our role and that of CQC in the event of provider failure due to quality or financial reasons, and suggest there could be legislation to define the actions that can be taken by the local authority in these circumstances to allow a managed run down of a care home which would be in the best interests of residents. If the economic regulatory response is to be different from the quality and safeguarding response, with a different regulatory body, there will need to be clarity about the interplay between the two.

7. Integration of Health and Social Care

7.1 Hampshire County Council is committed to integrated working, for example working with Health on end of life care, the armed forces welfare pathway and integrated community equipment service. The additional funding for re-ablement has been particularly welcome in meeting joint priorities.

7.2 It is important to recognise that the focus of integration must be the removal of barriers to the service user receiving a seamless service, regardless of which agency delivers it. Integration of the organisations per se should not be the objective. There needs to be a clear focus on outcomes for individuals and a clear lead organisation. There need to be mechanisms in place to transfer funding between organisations, and contractual levers to ensure integrated outcomes are met.

7.3 The strategic direction needs to be set by the Health & Wellbeing Board through the priorities identified by the Health & Wellbeing Strategy. Integrated services for individuals will need to be driven by the emerging Clinical Commissioning Groups, and through personal budgets and service user and patient empowerment.

7.4 We welcome the commitment to offer personal health budgets to all those receiving NHS continuing care, and would urge the pace of rollout to be increased, and the scope extended. Hampshire has recently become a pathfinder for offering personal budgets for special education, health and social care to parents of children with disabilities and SEN (special educational needs) as part of the South East 7 group of local authorities.

7.5 We would welcome clarification of the processes relating to NHS continuing care, NHS continuing care as it is currently established can create a conflict of interests between health commissioners as guardians of public funds and health commissioners as gatekeepers to statutory entitlement, and therefore some degree of
Ev w56  Health Committee: Evidence

independence in decision making processes could substantially aid transparency in the allocation of continuing care funding.

7.6 The transfer of public health responsibilities to local authorities will improve integration, but it will be important to that public health is sufficiently well resourced to maintain focus on early intervention and prevention.

7.7 Hampshire County Council already works closely with Health on safeguarding, and we have recently developed a joint contingency plan to provide for the eventuality of sudden closure of a residential home. However the issue of roles and responsibilities, in relation to safeguarding, of the various organisations being set up as a result of NHS reorganisation needs to be resolved rapidly. This is a priority because we are seeing an increasing number of cases of institutional abuse which require a response across health and social care. In order to avoid such cases health and social care staff need to work together to address issues early on. Institutional abuse/neglect cases are resource intensive, and better integrated working would mean quality issues could be picked up at an earlier stage.

8. PRIORITIES FOR REFORM

8.1 Our primary concern is that any reform is both sustainable and affordable in the current context, takes into account the whole social care system, and allows for local priorities and local innovation. Our priorities for reform would be: improving early intervention and prevention services, including information, advice and guidance; implementing law reform; improvement of processes for NHS continuing care; continued funding for re-ablement; increasing the capital threshold for both domiciliary and residential care.

October 2011

Written evidence from WRVS (SC 26)

INTRODUCTION

WRVS is the largest voluntary organisation delivering preventative care nationally for older people locally. 43,000 volunteers provide support to 100,000 older people every month and WRVS is committed to enhancing the quality of life of older people. A central means of achieving this ambition is the provision of preventative care which can take many forms. These include helping older people remain socially connected and involved in the community, providing practical forms of help in homes to help manage disability, improving nutrition, transport, and signposting people to sources of information that help them access the services and support that they need.

OVERVIEW

WRVS research found that the reablement funds have not been used to promote greater independence amongst older people and have been spent on a narrow set of services.

WRVS’s Shaping Our Age consultation with older people across the country found that services designed to overcome loneliness and isolation were their top priority. However in many local authority areas these services are being curtailed.

WRVS published a report looking at the impact on older people of public spending cuts on Sweden and Canada. The report found that health outcomes for older people in both countries worsened.

2010 SPENDING REVIEW

WRVS believes that the £648 million transferred from the NHS to social acre should be read in the wider context of Spending Review objectives. In particular it should be viewed with section 2.14 below from the Department of Health section of the 2010 Spending Review document set out below:

FAIRNESS

2.14 Social care plays a vital role in helping to keep people healthy and independent. It also supports some of the most vulnerable people in society. The Spending Review therefore makes available sufficient resources for local authorities so that they do not need to reduce access to services, and can fund new approaches that improve outcomes for those receiving social care:

This view is consistent with the Health Committee view published in December 2010 that strongly supported working towards an improved interface between health and social care. The Health Committee also stated in paragraph 20 that “it will be an opportunity missed if this sum (£1 billion) is not distributed with the primary aim of developing a better overall interaction between health and social care which could have a much wider impact on efficiency, prevention and reablement than the more limited funding of certain services”.

WRVS believes that there is a real danger that the opportunity to improve health and social care will be lost as any additional funding will be used to prop up and protect some existing services and not spent as expected.
The Collection of New Evidence

Survey of Primary Care Trusts Spending On Social Care

WRVS has been involved in gathering new evidence on what older people want and how English Primary Care Trusts (PCTs) were spending the reablement funds transferred from the NHS. Both reports will be published in the next few months. A summary of the headlines of these studies are included in this submission. In addition WRVS has views it would like to express and WRVS would welcome the opportunity to provide an oral presentation of this new evidence.

1. Earlier this year, WRVS surveyed all English PCTs asking them how they are spending the reablement funds. The findings will be presented in a report, Current trends in joint commissioning: reablement, well-being and the voluntary sector. The report is written by Dr Tania Elias and Dr Chia Lang, two geriatricians.

WRVS followed up the Department of Health’s circular of January about the £150 million allocated for reablement in 2011–12 as part of its commitment to further preventative care with a FOI request to identify how far health commissioners had embraced the Government’s prevention agenda. Around 40% responded. WRVS asked the following:

— how they intended to spend their reablement funds;
— what stage they had reached in establishing joint working with local authorities to produce an integrated service; and
— how they were consulting voluntary organisations as part of their plans to commission services.

The headline findings were that only a small number of PCTs focused on promoting well-being, social inclusion and overcoming isolation, with services such as day care and community transport. In addition only small numbers of PCTs report using qualitative analysis measures, such as collecting feedback from service users, in order to decide how to invest the reablement funds. Only a small proportion of PCTs were commissioning services from the voluntary sector in order to achieve reablement goals. Only half of PCTs provided objectives and rationales for investment plans. One third of PCTs demonstrated some evidence of increasing commitment to joint commissioning.

In conclusion the report found that most PCTs are not investing in services designed to improve older peoples independence or well-being and that most have not shown evidence of gearing up on joint commissioning.

Shaping Our Age

2. Shaping Our Age is a three year Big Lottery Funded project which aims to gather direct evidence from older people about what services and support would enhance their well-being.

The key findings from Phase One of the project, in which a diverse range of older people defined well-being, the factors that shape it; the barriers to well-being; the impact of services on well-being and suggested improvements are summarised below. Participants shared their views and concerns with us in focus groups and qualitative interviews.

How Older People Defined Wellbeing

— Wellbeing and older people—healthy, pain free and able to live independently: happiness, contentment, satisfaction, peace of mind, comfort, enjoyment and euphoria. It is also associated with feelings of self-worth and achievement. Relationships and social contacts contribute to well-being.
— Keeping busy—being active helps divert attention from ill health. Particularly important are groups and clubs, which provide structure to lives and “something to look forward to”. Benefits are gained from volunteering, supporting others and campaigning.
— Good health—physical or mental—is key for an independent, active and happy life. Innate character also plays a part. Those with a positive outlook, self-motivation and resilience are better placed to achieve a sense of well-being. Faith, religion or spirituality can play a role. Having sufficient personal finances can also be a factor.

The study found that overcoming loneliness and isolation was central to older peoples well-being. This was more important than concerns about lack of money and personal finances.

The Impact of Services on Older People’s Well-Being

Positive aspects include:

— Good relationships and professional attention from GPs.
— Good hospital services and treatment and support from a range of other health services.
— Local council services especially housing, library and housing services.
— The voluntary sector for locally based services and personable volunteers.
— Concessionary bus fares and public and community transport.
Negative aspects include:

— Poor communication and difficulties in making GP appointments.
— Poor treatment from hospital staff.
— Poor hospital hygiene.
— Poor mental health and counselling services and poor disability awareness.
— Negative attitudes towards older people—lack of respect, empathy, listening, compassion and a neglectful culture.
— Irregular and inefficient public transport services, poor connections and access issues.
— Poor care services at home and in some residential homes.
— Closure of community centres, libraries, post offices and potential cutbacks in transport services and concessionary fares.
— Difficulties in accessing information about services, especially with more digitisation of information.

**Barriers:**

— Poor physical health and impairments are main barriers to well-being.
— The ill health of others, especially close family, can also be a barrier to well-being especially for carers. Mental ill health is a common problem and especially depression and dementia.
— Other health issues mentioned include insomnia and the side-effects of medication.
— Isolation and loneliness in old age are considered to be the biggest problems and especially so for people confined to their homes, the recently bereaved and people unable to speak English.
— Limited finances and poverty in old age are a concern for many. Main issues highlighted were the inadequate state pension and unclaimed benefits.

**Suggestions for Improvements by Older People**

— Overall, a desire that older people play a more active role in improving their own well-being, but also a sense that the help and support of others is needed to achieve this.
— Getting involved in groups and activities, volunteering, campaigning and shaping services and policies. Suggestions were made for helping to facilitate wider forms of involvement including support for minority ethnic older people; better access for older people with physical and sensory impairments and reliable public and community transport.
— Treat older people with respect and dignity and to improve communication, build trust, give people more time, and value the whole person.
— Practical support in people’s own homes by reliable competent and trustworthy people; particularly help with small jobs about the house and garden and shopping. Also support at critical times such as following bereavement, failing health and coming to terms with impairments.

**International Experience**

3. WRVS has also been looking at the impact of spending cuts in other countries on the health and wellbeing of older people. On 6 September WRVS published a report looking at impact on older people of fiscal consolidation measures made in Sweden and Canada—Public spending cutbacks and the impact on older people: The Swedish experience in the 1990s. WRVS asked the research consultancy, SQW, to study Sweden a country that like Britain, underwent drastic cuts in public spending in order to reduce its budget deficit. SQW also then looked at Canada, a country that also made big budget cuts to see if its findings were supported by this country’s experience. Although both countries sought to lessen the impact of budget cuts on older people, nonetheless the researchers found the following:

— Older people in Sweden experienced a sharp decline in their state of health, including in pain and psychological distress.
— There was an increase in the number of Swedish older people who fell below the poverty line.
— There was a 69% reduction in geriatric hospital beds, in large part due to cutbacks and not health prevention.
— In Sweden cuts in social care saw more pressure on women and families.
— There was a big increase in the caring burden faced by women and family members as care services in Sweden were scaled back dramatically (one in seven older people in Sweden who needed home help could not afford it).
— In Canada there was an increase in the mortality rate of Canadians over the age of 85 with a particularly dramatic increase in the rate for people in their nineties.
WRVS position on the question “The practical and policy implications of the Government’s stated commitment to promote integration between health and social care services”

WRVS has a wealth of expertise in delivering preventative social care at a local level. WRVS strongly supports the finding and conclusions of the Dilnot Commission. Moving towards a system where individuals know how much they will need to contribute towards paying for long term care could relieve pressure on many families. However long-term care is only part of the wider picture of provision that enables people with disabilities, older people and their carers are enabled to have fulfilment and dignity. Unless ministers pursue this level of ambition, then more people are likely to be pushed into residential care regardless of the balance of contributions made by the individuals and the state.

The system has to reduce the vulnerability of older people and this makes it essential that the retrenchment of home care provision is reversed. Prior to the cuts programme, 300,000 fewer people were receiving state funded domiciliary care support. There is now a well-established trend of local authorities restricting care services for those people with the most severe needs and this has intensified since 2010. The 2008 Commission for Social Care Inspection argued that this policy was self-defeating as it only pushed up costs in the longer term. The Dilnot report concludes that there are unacceptable variations in eligibility for services across the country. In Wales, WRVS has already called for harmonised eligibility criteria.

WRVS was pleased to see that the Dilnot report concluded that preventative care is beneficial. As the Commission report says, these activities have the potential to stop an individual’s needs escalating. WRVS has long argued that preventative care should focus on overcoming the loneliness faced by many older people and helping them manage life challenges, like bereavement and returning home after a spell of hospitalisation. Department of Health funded research showed that it is often older people with lower care needs where the taxpayer could derive the greatest benefits from preventative services. However, this is exactly the group who are having services withdrawn from them at the moment. WRVS commissioned research undertaken by Frontier Economics also found that social care services in Staffordshire could reduce demand for long-term care.

The missing link, to some extent, in the current debate about long term care is that whoever is going to pay, right now local authority cuts are pushing more people closer to the point when they will need to leave their homes.

The squeeze on eligibility criteria is a major concern. The Department’s Vision statement publish in November 2011 was that there was no need to further restrict preventative care. The Secretary of State assured the Health Committee repeatedly in earlier evidence that the social care settlement would be enough for councils to meet social care demand without tightening their eligibility criteria. However, from our own research we know that 15 local authorities raised the threshold in 2011. This is borne out by other work. This is despite the transfer of £800 million of funding from the MHS to local authorities. With further local authority savings due to be made in the coming years and an increased demand, this will place an additional strain on maintaining eligibility criteria. This will be an enormous challenge and one we are not sure that local authorities will be able to meet.

It is becoming clearer through the growing number of legal challenges that local authorities are facing that some local authorities have acted in haste and have not properly thought through the consequences of their actions or made alternative arrangements. Following on from the Birmingham City Council defeat in the Courts in June over its decision to restrict access to social care to those with most critical needs, last week the High Court allowed a full judicial review of the Isle of Wight’s plans to take similar action. A report compiled by Poole Local Involvement Network six months after a tightening by the local authority of eligibility criteria from moderate to substantial needs, indicates that damage is being done to the wellbeing of older people and may cost more in the longer term.

WRVS wrote to Social Care Minister Paul Burstow in July asking what action the Government would take to ensure that local authorities are not in breach of their legal obligations. In responding the Department admitted that further legal challenges may well be brought against authorities and they may be found to have acted unlawfully if they did not have regard for the relevant equalities legislation. WRVS believes that this is not an appropriate response. Older people deserve fairness and clarity when seeking support when their health begins to fail. We accept that the eligibility criteria require a comprehensive review and overhall, but a ceiling of substantial must be introduced as a matter of urgency as recommended by the Dilnot Commission. Not only is this fair but it addresses the issue around portability.

Better use of data could arm both the NHS and local authorities with the information that they need to organise care and provide a greater integration of services. For example audits that examine the admissions or readmissions of older people could provide information to help that older person to return home more quickly into a safer environment and to reduce the number of emergency readmissions. The number of delayed transfers has been on the increase since March. Department of Health figures show that during Jan-March 2011 older people aged 75+ accounted for 75% of delayed acute transfers. However, the Department has now stopped collecting this data which means that any increase in delays in this age group can no longer be measured and then acted upon. This is short sighted and the data should be collection should be reintroduced.

October 2011
Written evidence from the Royal National Institute of Blind People and Action for Blind People
(SC 27)

EXECUTIVE SUMMARY

We have focused on three of the questions at the heart of this Inquiry: the practical and policy implications of the Government’s plans for funding social care; the recommendations made by the Dilnot Commission; and the recommendations made by the Law Commission. Although questions relating to variation in access to care services and personalisation are important we wanted to address the key issues Government needs to answer by April 2012:

— We welcome the Law Commission and Dilnot reports as serious and considered attempts to place adult social care on a sustainable footing.
— We urge the Government to reach a decision on the future of care funding because, without this leadership, we fear blind and partially sighted people will continue to experience a system which is unresponsive to their needs.
— The capped costs scheme is the only serious model put forward to date, but the Government must give further thought to the level of the cap so as to prevent unintended consequences.
— We would firmly oppose DLA-style reforms, which look for savings from the Attendance Allowance budget to help plug a shortfall in state funding.
— RNIB Group is delighted with the Law Commission’s recommendation on the registers for blind and partially sighted people. Making it a duty on local authorities to keep the registers is crucial.

In preparation for our response to the Inquiry, RNIB Group85 consulted 25 service users to establish their priorities for reform. One of the recurring themes was the shocking lack of support provided to people living with sight loss.

1. WHY CARE REFORM MATTERS TO PEOPLE WITH SIGHT LOSS

1.1 Being blind or partially sighted impacts on the ability to undertake a wide range of everyday activities. Notwithstanding this, blind and partially sighted people often tell us of their frustration that community care assessments fail to address their needs. We also hear from people who undergo an assessment only to learn that their social care needs are judged low or moderate, which frequently means they cannot get access to state-funded care:

— Around half of blind and partially sighted people feel “moderately” or “completely” cut off from people and things around them.
— One fifth of people say they do not recall receiving any visit from social services in the year after they registered as blind or partially sighted.
— In the year after registration, less than a quarter (23%) of people who lost their sight say they were offered mobility training to help them get around independently.

1.2 Research we have undertaken over the past few years highlights the paucity of care and the extent to which blind and partially sighted people rely on extra costs benefits to meet their daily living needs.86 The responses to our questionnaire on social care reform provided us with yet further proof that the social care system is not delivering for people with a visual impairment. It is very much in that context we welcome the Law Commission and Dilnot reports as serious and considered attempts to place adult social care on a sustainable footing.

1.3 What we believe the priorities for reform to be:

— An increase in the support available to people, in particular soon after someone develops a long-term condition or disability. Care and support should promote independence and prevent long term dependency;
— Maintain a system for meeting disabled people’s additional costs. Benefits like Disability Living Allowance87 and Attendance Allowance provide vital support to blind and partially sighted people; we warmly support Dilnot’s recommendation that universal disability benefits should continue as now; and

85 RNIB Group brings together a number of sight loss charities. On this occasion we have worked with our Associate Charity, Action for Blind People, to get a better understanding of blind and partially sighted people’s views following the Dilnot and Law Commission reports. We managed to secure responses from 25 individuals. The responses we received can only provide a snapshot of visually impaired people’s diverse experiences but we have used their insights to help inform this submission.

86 Fimister, G “Quality of life and independence: Why Attendance Allowance is so important to blind and partially sighted people” (RNIB, 2011).

87 Subject to legislation, Disability Living Allowance will be replaced by Personal Independence Payment (PIP) in 2013. Personal Independence Payment will be targeted at disabled people with the greatest needs. Some interest groups have estimated this could mean thousands of disabled people finding themselves ineligible for Personal Independence Payment, a loss of income that would prove devastating if individuals were also ineligible for state-funded social care.
— A fair settlement on funding so individuals are clear on the extent of their personal responsibility to plan for future care needs, but the Government accepts the responsibility it has for funding social care too.

2. THE GOVERNMENT’S PLANS FOR FUNDING SOCIAL CARE

2.1 We understand the Government will publish a Progress Report on funding around the same time that it publishes its White Paper. This should be next spring. RNIB Group thinks law reform and the question of funding social care should be dealt with within one White Paper. Modernising social care is to a very large degree contingent on solving the funding problem so we were concerned to hear there would be a separate Progress Report. Committing to a separate report suggests the Government will take a longer period of time to resolve some of the questions posed by the independent Commission on Funding of Care and Support.

We urge the Government to reach a decision on the future of care funding because, without this leadership, we fear blind and partially sighted people will continue to experience a system which is unresponsive to their needs.

2.2 On 29 June 2011 the Minister of State for Care Services described the idea of a fully state-funded system as “a fantasy”. He commented “the boat has sailed on a wholly tax-funded social care system”. RNIB and Action for Blind People understand the need to ground our aspirations for care reform in political and economic realities. Historically our position has been that we should do everything we can as a country to “pool the risk” that any one of us could develop significant care needs. Specifically we favoured a system funded from general taxation with the least possible expectation of private supplementation.

2.3 Recognising this is not where the debate is currently situated we favour whichever funding model gets us nearest to this vision of “risk pooling”.

We therefore welcome the Commission on Funding of Care and Support (Dilnot’s) proposal to limit individuals’ liability for paying towards their own care costs. We believe the Government should heed his message that additional state expenditure on care would need to increase by £1.7 billion in 2010–11 prices. As Dilnot himself explains, this represents one four hundredth of public expenditure.

2.4 At this stage it is difficult to state with real certainty what the practical and policy implications of the Government’s position on funding will turn out to be. The Government has generally been quite welcoming of Dilnot but it is still unclear whether the Treasury will accept a capped cost system which requires an additional £1.7 billion in public expenditure. One of the criteria the Dilnot review was tested against was value for money. We know from the recent National Adult Services Conference that the Care Services Minister remains committed to a sustainable settlement on long-term care.

Clearly there is some nervousness inside Government, especially when it comes to the costs of implementing Dilnot. Nonetheless the recent ONS statistics on a rise in life expectancy should remind us all that the costs associated with not acting will be very severe indeed. The Chancellor of the Exchequer must not shrink from the challenge of sorting out care funding.

2.5 We support a partnership model but we are clear this can only be achieved if the state recognises its proper responsibility for funding care. A capped cost approach is only realistic in our view if it minimises disabled individuals’ liability; especially given potential lifetime costs can reach catastrophic amounts. The £35,000 limit sounds reasonable. Inevitably some people will view it as too high: the Government may view it as too low. Whatever the merits of setting the cap at the £35,000 level, Dilnot is clear that a capped cost approach requires additional public expenditure.

To stimulate market solutions so individuals can effectively insure themselves the Government needs to provide firm leadership. That means delivering a partnership model that attracts the support of financial services, but we are certain a voluntary insurance model along the lines the Conservatives outlined in their report will not deliver for blind and partially sighted people.

3. THE DILNOT COMMISSION

3.1 There is a debate to be had about whether £35,000 represents the right amount for a cap. Generally speaking, people with fewer care needs but modest savings might pay for the full amount of their care costs without seeing the state contribute a huge amount towards the funding of their care package once they reach the cap. This is perhaps more likely where someone has a new diagnosis, is judged to have social care needs as they adjust to an illness or disability, but then, over time grows in independence, rendering them ineligible for ongoing care support.

3.2 The Government needs to examine the impact of a £35,000 cap on individuals who ask for that “little bit of extra help”: if someone who loses their sight needs intensive support soon after diagnosis they may only need lower cost or preventative care a few years later. That could mean they never reach the cap (but pay for services when they first become disabled, so for example mobility training which they really ought to receive...
The capped costs scheme is the only serious model put forward to date, but the Government must give further thought to the level of the cap so as to prevent unintended consequences. For example we need to guard against a system that disencourages disabled people from choosing expensive forms of care. One potential effect of a capped costs system, which would prove particularly perverse, would involve local authorities dissuading disabled people from buying in care that is priced in such a way it would get them nearer the level of the cap in a shorter period of time.

3.3 The Dilnot Commission observes not everyone will be able to afford their personal contribution. Dilnot also recognises those currently just outside the eligibility for means-tested help are not adequately protected.

To address this, the Commission recommends means-testing support should continue for those of lower means, and the asset threshold for those in residential care beyond which no means-tested help is given should increase from £23,250 to £100,000.

We would like greater clarity about the interaction between a cap of £35,000 and raising the means test so we can establish the asset level someone would start to pay towards their own care.

3.4 This appears to be a progressive package of reforms. Those on the lowest incomes and with the least accumulated wealth will be protected under the new system.

Younger and working age disabled people

3.5 It is crucial a settlement on social care funding recognises the needs of younger and working age disabled people. Blind and partially sighted people of working age are more likely than their non-disabled peers to live in relative income poverty. Two thirds are not in work. This means people with sight loss often face greater lifetime costs but find it harder to save or accumulate the assets that would enable them to contribute significant amounts to their own care. The new system needs to be seen to be fair.

3.6 We are pleased means-testing will continue for those of lower means but there is another group of people we need to consider: people who are of working age who may go on to lose their sight in later life. They may only have modest savings so it would require great planning on their part to insure themselves against the risk they might become disabled in later life. The Government will need to be especially proactive in encouraging and supporting such groups to plan for an uncertain future.

Universal disability benefits

3.7 We are especially delighted with the Commission’s recommendation on maintaining universal disability benefits but in truth it is not what Dilnot recommends, but rather, what the Treasury decides that matters to blind and partially sighted people. We need to guard against any attempts to raise the extra £1.7 billion Dilnot says the state needs to spend by means-testing or further restricting eligibility for Personal Independence Payment (for working age adults) or Attendance Allowance (for people aged 65 or over).

3.8 At this stage it is hard to say with real certainty what a re-branding of Attendance Allowance (AA) would mean for the 55,000 plus AA claimants with sight loss. We are happy to work towards a more streamlined social care assessment that is aligned with assessments for disability benefits.

We are firmly opposed to DLA-style reforms which look for savings from the disability benefits budget to help plug a shortfall in state funding. Attendance Allowance is often described as the original personal budget. Its role in preventing an escalation in blind and partially sighted people’s care needs cannot be underestimated.

Residential care

3.9 Dilnot recommends people should contribute a standard amount to cover their general living costs, such as food and accommodation, in residential care. The Commission believes a figure in the range of £7,000 to £10,000 a year is appropriate. Paying a contribution towards the accommodation costs would particularly affect people with profound or complex disabilities whose care costs tend to be higher and for whom a long stay in residential accommodation is not unusual. If someone has received care at home for a number of years but then, perhaps on getting older, decides to move into residential care, asking him or her to contribute an additional £7,000 to £10,000 a year could come as a shock.

Eligibility

3.10 Dilnot recommends that eligibility criteria for service entitlement should be set on a standardised national basis to improve consistency and fairness across England. In the short term, Dilnot thinks it is reasonable for a minimum eligibility threshold to be set nationally at “substantial” under the current system. This is obviously welcome, at least in theory.
3.11 However, it is worth mentioning that many local authorities mistakenly do not regard blind and partially sighted people as having “substantial” care needs, so the short term recommendation for a minimum eligibility threshold set at “substantial” would not, in itself, improve access to care services. We support attempts to improve portability of care assessments, which was separately dealt with by the Law Commission and more recently, in a Private Member’s Bill in the House of Lords.

Planning ahead

3.12 If a cap of £35,000 were to be introduced, people could be looking at paying an insurance premium of around £15,000. This is clearly not an inconsiderable sum, and even with means testing in place, many working age people with modest savings would find it difficult to plan ahead when they have other costs to consider.

3.13 The Commission recommends the Government should develop a major new information and advice strategy to help when care needs arise.

This is extremely good news, but a good information and advice strategy costs money, again an issue when the price tag for social care reform is making the Treasury nervous. We backed the Law Commission’s proposal for a statutory duty to be placed on local authorities to provide information, advice and assistance to all residents with care needs. If such a strategy were to come into fruition—and a statutory duty was legislated on—this could help the many thousands of blind and partially sighted people who are screened out of care services and left with nowhere to turn to.

4. THE LAW COMMISSION

4.1 We were extremely pleased with the report the Law Commission produced. On the whole we think their recommendations were uncontroversial.

Registers for blind and partially sighted people

4.2 The Law Commission considers that the duty to establish and maintain a register should be maintained but only in relation to blind and partially sighted people.

4.3 RNIB Group is delighted with the Law Commission’s recommendation on the registers for blind and partially sighted people. The registers mean people who have lost their sight can receive the early support they need to remain independent. Making it a duty on local authorities to keep the registers is crucial.

There is still a risk that the government could abolish the registers as part of its overall attempt to modernise social care. We generally welcome the aim of simplifying the law but streamlining the legal framework must not undermine existing entitlements, for instance to rehabilitation and registration, both of which serve visually impaired people very well.

5. CONCLUSION

5.1 The Dilnot and Law Commission has engaged extensively with RNIB, third sector organisations and many other people with an interest in the future of social care funding.

5.2 Dilnot has developed a workable blueprint for care reform which passes the government’s own tests on fairness and affordability. Dilnot was asked to develop a vision which would be fit for the future. The recommended increase in state funding—which Dilnot believes would be enough to make the partnership approach viable—represents less than half a per cent of GDP, not a huge amount when you consider how health spending has grown in comparison in recent years.

5.3 The ensuing debate about care reform needs of course to be grounded in economic and political realities, but it would be indefensible if the current narrative on deficit reduction was used as an excuse not to sort out a failing system. Our care system needs to be reformed to serve future generations so inaction is not an option.

5.4 We are delighted Attendance Allowance and other disability benefits will be protected as non-means tested cash benefits. We expect the Government to honour manifesto commitments to maintain extra costs disability benefits for people of retirement age.

5.5 We are also very pleased the Law Commission recognises the central role the process of registration plays in enabling blind and partially sighted people to access independent living support. We see no reason why the Government shouldn’t act on the Law Commission’s recommendation to maintain a system of registration for people with a visual impairment.

October 2011
Writen evidence from the Voluntary Organisations Disability Group (SC 29)

1. Introduction

1.1 This submission comes from the Voluntary Organisations Disability Group (VODG) the leading national umbrella group of voluntary sector social care providers for working age disabled people. VODG is a registered charity and its members support people with a wide range of physical, sensory and cognitive impairments, including people with learning disabilities. Member organisations, in partnership with local government and the NHS provide social care support to a million disabled people, delivering in excess of £1.5 billion of services.

1.2 This submission focuses on three areas:
   - Personalisation—and in particular the need to accelerate the pace and depth of reform;
   - Relocation between areas—and the unacceptable barriers many disabled people face when wanting to progress to less institutionalised settings; and
   - Economic regulation—and the important distinction between not-for-profit voluntary providers and commercial for-profit companies.

2. Personalisation

2.1 All of our members deliver personalised services of varying types and the VODG fully supports the principles and mechanisms of personalisation and in particular personal budgets (PBs) and the use of direct payments (DPs). We are an original signatory to “Think Local, Act Personal”, partnership and believe that providers, along with commissioners have a shared responsibility to design and deliver personalised support in ways that customers want. Fundamentally we believe it is essential that disabled people and their families, or advocates, are put at the centre of planning individualised and co-produced support solutions.

2.2 However we are concerned at both the pace of reform and its “depth”. By pace we mean the fact that there are only circa 340,000 people in receipt of PBs, with significant inconsistencies in the progress made between local authorities and that just 120,000 of this total number receive a DP, 15 years after they were first introduced. Additionally there has been low growth in the number of DP recipients in the past year.

2.3 By “depth” we mean that of these 340,000 recipients approximately a fifth receive less than £20 per week and there is scepticism within the sector about the approach being adopted by some local authorities towards PBs and the way they are “counting” PB recipients. It appears that some authorities are driven more by the governments’ target of having all eligible recipients on PBs by 2013 than perhaps they are of ensuring the funding-mechanism is used as a means to an end and that PBs are truly empowering, personalised and of growing influence in terms of market shaping and reform. We are told that some service users have learnt they are in receipt of a PB without previously having known about it.

2.4 This suggest that there is an element of “box-ticking” going on when it comes to counting the numbers of PB recipients and the VODG believes that this is an area that merits further in-depth analysis. Councils need to provide more flexible PB systems and processes if they are to transform the lives of working age disabled adults and achieve the best results. The processes used for delivering PBs are more difficult than they need to be and more work needs to be done to make DPs more accessible, particularly to carers. There is also a need to simplify the rules and regulations surrounding PBs.

2.5 PBs are delivered of course within the current context of substantial local government budget cuts and the VODG is concerned about how difficult it is now generally for disabled adults to qualify for support—via a PB or by some other mechanism. Significant numbers of people are deemed ineligible for support due to them not meeting local eligibility rules and it is not clear where these people turn to for support. This seems to us to be an inefficient and short-term approach to determining who should qualify for support and who shouldn’t and one which works against developing a preventative, whole-community, long-term economic and person driven approach.

2.6 We would like to see the local authority financial “gate-keeper” role, separated from the care assessment process and the development of a longer-term personalised care planning process and relationship, based on the principle of delivering “just enough support, just in time”. This approach we believe would be more preventative and economic over the longer-term, achieve better outcomes for individuals and communities and would potentially make better use of social capital and circles of support.

2.7 Inconsistencies in the current social care system (the post-code lottery) have been widely commented on over many years. In our view the government should seek to deliver a “national social care service”, based not simply on portability of assessment, which we believe will have a limited impact but on portability of funding. (See section below on relocation).

2.8 This suggests for those deemed eligible a national minimum level of social care entitlement which would in-part help to overcome existing inconsistencies in eligibility rules and local interpretation of FACS; it would also help to enable greater movement of disabled people from area to area.

2.9 Finally we believe that strong value driven relationships between providers and commissioners allows for the design of personalised and cost-effective, high quality support. There is an urgent need to transform commissioning so that it is less about procurement and more about strategic and personalised commissioning.
This way the commissioner spends less and does the right thing. The provider wins the opportunity to put their values into action and the individual achieves outcomes that enrich their life and wellbeing.

3. Relocation

3.1 In 2007 the Voluntary Organisations Disability Group’s report “No Place like Home” called for urgent action by the Department of Health to sort out the bureaucratic muddle which adversely affected the lives of disabled people trying to move home. The root cause of the problem was the definition of someone’s place of ordinary residence—the means by which local authorities and Primary Care Trusts (PCTs) determine which authority has responsibility for financing care services for people living in their area.

3.2 Local authorities and PCTs were using disputes over a person’s place of ordinary residence as a device to delay, or avoid paying, the costs of care. The report highlighted that this was discriminatory against disabled people, as well as infringing their human rights and in contradiction to stated government policy.

3.3 Disputes between local authorities and PCT’s over who should pay for a person’s care were causing untold distress to the people concerned as well as wasting millions of pounds of public money.

3.4 The VODG called on the Department of Health to:

— establish and enforce the principle that a person should receive appropriate social care and support from the authority where they were currently living, or wished to live, regardless of circumstances;

— update the guidance to social services and PCTs to ensure they implemented this principle in a person-centred way and removed barriers to choice and independence; and

— put in place a framework for the transfer of funds between authorities so that the issue of ordinary residence could no longer be used as a basis for refusing to provide care and support.

Four years later only one of these recommendations has been acted on.

3.5 In April 2010 new government guidance came into effect on the application of the ordinary residence rules. The guidance recognises the shift towards independent living and that social care is being delivered in new and innovative ways. However, it only clarifies the rules. It does not address the key issue of transfer of funding.

3.6 On October 1 2010 the new Equality Act was introduced—protecting individuals from unfair treatment and promoting a fair and more equal society. And one of the key underpinning principles of the government’s White Paper, “Equity and Excellence: Liberating the NHS”, is that of, “choice”. “Patients will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment”. This means, “Money will follow the patient through transparent, comprehensive and stable payment systems across the NHS to promote high quality care, drive efficiency, and support patient choice”.

3.7 Despite this, the principles of personalisation and of funds following the individual does not currently apply to disabled people wishing to exercise choice and move from one local authority area to another or from one care provision to another—denying them access to their basic human rights and citizenship as members of a fair and equal society.

3.8 It seems likely that the government in its forthcoming White Paper will introduce a national and portable care assessment, this is not a new idea, but the VODG would argue that a portable care assessment is limited in value without connected portability of funding, as each local authority will simply continue to set their own eligibility rules and determine (locally applicable) levels of funding. This means that even with a portable care assessment significant restrictions on personal mobility will remain.

3.9 We do not understand why NHS funding is deemed to be “portable” (see the above quote from “Equity and Excellence: Liberating the NHS”), and yet successive governments have been reluctant to address this issue in relation to local government funded social care. This reluctance appears to directly undermine the government’s policy aims of independence, choice and citizenship.

3.10 The argument often put forward for maintaining the status quo is that change is too complicated due to there being “winners and losers”, where some local authorities are net importers of disabled people, ie they “host” high numbers of out-of-area residential placements and would therefore be unreasonably penalised. But if NHS funding can be moved around “with the patient” why can’t a similar arrangement be made for people funded by local government through an inter-authority funding transfer mechanism?

3.11 There is still a need for urgent action. People should be able to exercise choice of where to live and have control over the support they receive.

3.12 The Department of Health guidance acknowledges the key issues of ordinary residence—yet local authorities are still choosing to call it in to question. The cuts to local authority spending are making matters worse—the desire to “pass the buck” is even greater. If the funds could follow the individual, disabled people could exercise choice over where, and how, they live and VODG research suggests that there would often also be a saving to the public purse.
The VODG wants the government to:

- put its core principles of fairness and equality into practice by demonstrating effective leadership which resolves this issue once and for all;
- establish and enforce the principle of choice and that a person should receive appropriate social care and support from the authority where they were currently living, or wish to live, regardless of circumstances; and
- put in place a national minimum level of portable social care funding for all (see section on personalisation above) or at the very least establish a framework for the transfer of funds between authorities (similar to the NHS) so that the issue of ordinary residence is no longer used as a basis for refusing to provide care and support.

4. ECONOMIC REGULATION

4.1 We are aware of the proposal that Monitor will become the economic regulator for social care but despite the significant financial difficulties of Southern Cross and the distressing implications this had for their care home residents we believe that a distinction between not-for-profit and for-profit providers should be drawn.

4.2 This is not to imply that not-for-profit providers can never get themselves into operating difficulties but we would argue that the values, motivation, constitutional and governance structures of not-for-profit providers are fundamentally different to companies that are principally accountable to shareholders, or to private equity investors.

4.3 Many VODG members for example are historical charities (household names) some more than 100 years old that grew out of the Victorian philanthropic tradition or are based on explicit Christian values. They have been successfully delivering social care services throughout this time and their prime focus and motivation for doing so is to support their beneficiaries. In some cases the beneficiaries themselves are closely involved and influential in the governance and running of these organisations.

4.4 A number of these charities (providers) are “condition specific” organisations (e.g. RNIB/MS Society/ Epilepsy Society) and are synonymous with supporting and upholding the rights of people with these particular conditions; their motive is not to make a profit as an end in itself. In short these charities have a solid track record; they have operated for decades without economic regulation and we believe that it will be an unnecessary added burden and cost to the voluntary sector.

4.5 Critically charities have their assets in effect “locked in” by charity law and are required to to comply with the conditions in section 36 of the Charities Act 1993 (as amended), this means that although most trustees can sell their charity’s land without complication there are certain requirements that must be met:

- A charity must take written advice from a qualified surveyor.
- A charity must advertise the sale unless the surveyor says otherwise.
- The trustees (Directors) must be happy that what they are being offered is the best deal they can get.

Additionally in some cases the approval of the Charity Commission is required before selling property and the proceeds can generally only be used for the purpose of supporting their charitable purposes. Therefore this is fundamentally different from privately owned providers which can use their assets for the personal benefit of their owners and on disposal are not obliged to re-invest the proceeds in the business.

4.6 We also believe that the way the social care market is structured for working age adults is fundamentally different to that of older people, where there has been huge growth in private-payers and the supply of large volumes of places by three or four companies. This makes it difficult to envisage how economic regulation would work in practice. With perhaps 20,000 providers to licence and monitor it’s of a completely different scale to that of monitoring Foundation Trusts.

4.7 In contrast the vast majority of funding for working age adults comes through statutory funding of one kind or another (chiefly from local government), in other words there are very few private payers. This means that whilst the supply and payment of social care services for working age adults has some of the characteristics seen in other “markets”, there are also some important differences. These include the fact that customers are almost all drawn from the same source, in that they come through local government community care assessment processes, are funded by the same local authorities and there is limited movement (exits) of customers. It is also a hugely fragmented market on the supply side with a multitude of providers of every size.

4.8 This makes it difficult to envisage how economic regulation would work in practice. With perhaps 20,000 providers to licence and monitor it’s of a completely different scale to that of monitoring Foundation Trusts.

Many VODG members for example operate broad based charities and engage in a wide range of activities, some under contract to local government or the NHS, others funded by different income streams and some funded, or subsidised through fundraised income. Often the buildings that are used have been gifted to the charities and there are generally very low levels of borrowing in the voluntary sector compared to commercial businesses. It’s unclear how an economic regulator would unpick these financial structures and we are concerned about the potential costs of this activity (ie licensing and monitoring) which will have to be borne by providers and at a time of significant cuts in fee levels and extremely tight operating margins.
4.9 Despite successive governments saying they wish to see less red-tape we are concerned about the gradual creeping regulatory burden on the sector and the administrative costs of this. There appears to be a lack of coherence, or clear vision for social care regulation and in our view we are moving towards an inefficient and unsustainable system. Economic regulation will be one more administrative burden alongside, CQC, NICE and local government contract monitoring—which often overlaps with CQC inspection functions.

4.10 If the regulatory burden is not to be further increased in blanket-fashion there needs to be distinctions made between different types of providers, both by scale, geographic concentration of services and operating or constitutional structures (ie charities and social enterprises) and a “light-touch” system that recognises that many voluntary providers have been operating successfully in the “market” for decades without economic regulation.

*October 2011*

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**Written evidence from AKW Medicare Ltd (SC 30)**

**Executive Summary**

1. AKW Medicare Ltd is the market leading provider of Bathroom, Showering, Kitchen and Daily Living products for people with mobility difficulties.

2. Our home adaptations and products are vital in enabling individuals to stay in their own homes and live independently for longer.

3. Housing adaptations offer those in need of mobility assistance an alternative to residential housing or domiciliary care at significantly less cost to them and the taxpayer.

4. Furthermore, continuing to live in their homes (with or without some form of assistance) is almost always the preferred choice of those requesting adaptations.

5. The Comprehensive Spending Review announced that the Disabled Facilities Grant (DFG)—the main grant administered by local authorities for home adaptations for elderly and disabled people—would not be cut but critically removed its ring-fencing. We are concerned that, in practice, the removal of the ring fence means that the DFG is being eroded by other competing demands upon local authorities’ financial resources.

6. In late 2010, we submitted Freedom of Information (FOI) requests to 434 local authorities which revealed 14,451 fewer home adaptations in 2010 compared to 2009 representing a 22% reduction overall in the number of adaptations taking place.

7. We believe, however, that cuts in funding for home adaptations is a false economy, costing the NHS and local authorities vastly more in care services than the cost of home adaptations.

8. Furthermore, we believe that these cuts are significantly increasing the strain on the adult social care system, a system which is, according to the Dilnot Review “not fit for purpose and needs urgent and lasting reform”.

9. We strongly urge the Government in its Social Care White Paper to fully consider the role that housing adaptations can and should play in making the adult social care funding system more sustainable.

10. We would welcome the opportunity to expand on the above and below points in an oral evidence session with the Committee, should its members choose to call on us to appear.

**FOI Data Reveals Decline in Home Adaptations**

11. FOI requests were sent by AKW Medicare Ltd to 434 Local Authorities late in 2010.

12. They were asked the following:

   — Number of home adaptations carried out in their own housing stock in 2009.
   — Number of home adaptations carried out in their own housing stock in 2010.
   — Number of home adaptations carried out through DFGs in 2009.
   — Number of home adaptations carried out through DFGs in 2010.

13. 221 (51%) responded to the questions as asked:

   — There was a 26% reduction in the number of home adaptations carried out in the housing stock owned by these respondents (10,607 fewer adaptations).
   — There was a 15% reduction in the number of home adaptations carried out under DFGs by these respondents (3,844 fewer adaptations).

14. 139 (32%) Local Authorities based their responses on adaptations carried out during the fiscal years 09/10 and 10/1. As the fiscal year had not been completed this data has not been included in the analysis.
15. 74 (17%) Local Authorities did not respond or were unable to provide the requested data and were excluded from the analysis.

Consequences

16. With an ageing population, we are concerned that thousands of people who are mobility impaired but want to live in their own homes have to go into care or rely on the support of others because they are unable to have a home adaptation.

17. While the Chancellor said he was protecting the DFG in the Comprehensive Spending Review, we believe this has been undermined by the removal of its ring-fence which has led, in practice, to fewer home adaptations. This decline in the number of home adaptations is clearly illustrated in our FOI data.

18. This has created a false economy since those who are being denied home adaptations are no longer able to live independently, costing the NHS and local authorities vastly more in care services.

19. A Saga survey commissioned from Laing & Buisson and published in September 2009 found that the average annual cost of care homes across the UK is £36,348 per person.

20. A research report undertaken on behalf of The Office for Disability Issues in 2007 entitled Better outcomes, lower costs found that an hour’s home care per day costs £5,000 a year and adaptations that remove or reduce the need for daily visits pay for themselves in a time-span ranging from a few months to three years and then produce annual savings. In the cases reviewed, annual savings varied from £1,200 to £29,000 a year.

21. Better outcomes, lower costs also found that the average cost to the state of a fractured hip is £28,664 which is 4.7 times the average cost of a major housing adaptation at £6,000.

22. A typical adaptation, such as a level access shower, costs even less, at around £3,500.

23. In addition to cost savings, supporting elderly and disabled people in their own home enhances their quality of life and reduces burdens on carers.

Disabled Facilities Grant

24. We believe that the Government needs to make funding for housing adaptations a priority which will deliver overall cost savings with fewer people going into care or using NHS services.

25. The Government should therefore reverse its decision to remove the ring-fencing of the DFG and ensure that local authorities do not make cuts to the funding of home adaptations when our FOI data has revealed a significant decline in home adaptations in 2010 compared to 2009.

The Importance of Living at Home

26. As the All Party Parliamentary Group on Housing and Care for Older People’s report—Living Well at Home—noted earlier this year, living in their own homes can have significant positive impacts on older people’s quality of life, including:

— a suitable place to live can mean independence for far longer;
— it can prevent the need for residential care;
— it can reduce requirements for care at home;
— it can mean fewer accidents and hospital admissions; and
— it can allow people to leave hospital much earlier, with less risk of immediate readmission”.

27. Beyond improving the quality of older people’s lives, the report also comments on the financial benefits of people continuing to live in their own homes: “We have noted that relatively modest investments in helping people remain independent—that little bit of help in the home or quite simple adaptations, from hand rails to stair lifts—can save the costs and traumas of moving into residential care”.

28. It should also be noted that older people who go into residential care for temporary support often struggle to move back into their homes, causing a further pressure on Government social care budgets.

29. We agree with the APPG that Local Authorities should be encouraged to ensure that “every penny” of funding from the Disabled Facilities Grant is applied to ensuring that those with limited mobility are supported in living as independently as possible.

30. However, we would caution that due to the often severe pressure placed on Local Authorities’ budgets due to central Government funding reductions, Local Authorities often choose to use the DFS to fund other programmes beyond its intended remit.

Advice and Signposting of Services

31. It is also vital that Local Authorities take responsibility for advising and signposting the full range of services and other funding streams available to enable people to live independently, including self funders.
32. This could include a revenue stream to help support those who do not meet eligibility criteria for funding.

October 2011

Written evidence from Turning Point (SC 31)

ABOUT TURNING POINT

1.1 Turning Point is a leading health and social care organisation with over 40 years experience of providing support to adults with complex needs including those affected by drug and alcohol misuse, mental health problems and those with a learning disability. We work in over 200 locations, providing specialist and integrated services that meet the needs of individuals, families and communities across England and Wales.

1.2 We have also developed Connected Care, Turning Point’s model of community-led commissioning: currently working in 14 areas of England to integrate health, housing and social care.

1.3 We are a social enterprise reinvesting its surplus to provide the best services in the right locations for people with a range of complex needs who need them the most.

FUNDING FOR AN AGEING POPULATION

1.4 The funding of adult social care is a long standing issue that has yet to be fully addressed. The Dilnot Commission’s recommendations go some way to doing this and started the debate from the perspective of sharing costs and getting the balance right between the state’s contribution and that of individuals. There are many ways this could be put into practice. Insurance is one system, equity release is another as is taxation. There is a lot more to be done before this is agreed and come to fruition, however Dilnot has gone further than previous attempts to address the massive funding gap that exists.

1.5 The recommendations in the Dilnot Report were very much focused on how a sustainable care and support system can be achieved. Turning Point, as secretariat to the All Party Parliamentary Group on Complex Needs and Dual Diagnosis, joined other Groups in hosting a meeting attended by the Dilnot Commissioners to support its recommendations which “provide an opportunity to break through the stalemate and offer a funding system that provides clear entitlements to joined-up care and support and enables people to live well at home.”

1.6 A letter sent from the Chairs of the APPGs asked the Government to accept the urgent need for reforms, and commit to:

— Publish a White Paper by 2 April 2012 and include legislation on the Commission’s recommendations in the 2012 Queen’s Speech.
— A financial settlement that is enough to ensure that local authorities can deliver a fairer system of charging for care and that people have access to good quality joined-up care, support and suitable housing alongside the necessary information and advice.
— Continue to use the expertise of Andrew Dilnot and the other commissioners in the run-up to the White Paper with the secretariat in place to support them.

1.7 We trust that these points have been considered and their importance continues as the White Paper continues to be developed.

1.8 Whilst efforts to progress integration have been taken forward it is disappointing that we are still talking about health and social care funding as separate entities. They are inextricably linked: not only in terms of spend but also savings and where these are achieved. We hope the Social Care White Paper reflects the need and importance of integration, not only in provision but the funding of services. There is potentially a lot the health and social care system can learn from Community Budgets, currently being applied to families with complex needs, in terms of pooling resource around need, rather than treating needs separately based on funding streams.

1.9 The practical and policy implications of the Government’s plans for funding social care are going to be felt by people of all ages. Turning Point has been clear in its conversations with Andrew Dilnot, Health Ministers and in previous submissions to the Committee that social care funding cannot be focused solely on the needs of older people. There is still much to do in terms of ensuring people of a working age receive integrated, high quality care and support provision. That said one can not ignore the impact that an ageing population will have on the ability of the current system to sustain the support provided, and to fund it adequately.

1.10 It is very welcome news that people are living longer: “by 2026 the number of people aged over 85 is expected to double; adults with a learning disability will increase by 30% over the next 20 years and dementia...
numbers will double over the next years” (Kings Fund). However this has very specific resource and training implications that have not been addressed before. The Social Care White Paper will have a role to play in doing this and to ensure the workforce (both care providers and commissioners) are fully equipped for the changes ahead. Through coproduction with the sector and individuals in receipt of care and support, a social care strategy, based on the outcomes framework, is required to target resource and effort where it is needed, in much the same way as the many NHS and Public Health policy documents have set out.

1.11 As well as an ageing population of people with minimal care and support needs there are also an increasing number of older people with a learning disability, mental health conditions, substance misuse issues and other complex needs, who will require very specific ongoing care.

1.12 At Turning Point we are increasingly supporting people who are over 65, particularly in our learning disability. Over 37% of the 350 people with a learning disability we support are over 50 with 15% being over 65. This means the way we deliver services has to change as does the way our services are commissioned.

1.13 Currently we support people with a learning disability who also have dementia. Given the expected trends that point to an increasing number of people living longer with a learning disability, the number of older people with a learning disability and dementia will also increase. There is evidence that the early signs of dementia are often missed or misinterpreted in people with a learning disability. There is also evidence highlighted by the Alzheimer’s Society that 20% of people with a learning disability have Down’s Syndrome and people with Down’s syndrome are at particular risk of developing dementia. Research suggests that 54.5% of 60–69 year olds who have Down’s syndrome with have dementia. Local Authority Commissioners tend to try and move people once they have been diagnosed as having dementia to generic dementia services. We are therefore trying to engage in a dialogue with commissioners across the country to raise awareness of how important it is to try and keep individuals in their own home where our learning disability and dementia trained staff are able to continue supporting them.

1.14 The need for targeted dementia support for people who have complex needs, is something that will be raised increasingly as people with a learning disability and other complex needs live longer. The Social Care White Paper must reflect this as does any future funding system.

**Existing Variation in Access To and Charges For Social Care**

1.15 As an organisation working across England the scale and implications of variation across the country in terms of access, assessment, eligibility criteria and funding are obvious.

1.16 As the Kings Fund have highlighted, 82% of local authorities only provide support to those with substantial and critical needs. This leads to those with mild to moderate conditions going without support; their support being funded by themselves or their family; or only receiving support once their needs escalate to a high level.

1.17 The lack of a consistent approach to assessments, definition of need and the variation in charges also undermines any real sense or opportunity of portability. We welcomed the Law Commission’s stance on simplifying assessments and the Government’s support for portability. However the Social Care White Paper has to be clear on how this will translate at the local level into practice.

1.18 If people want to move to a different part of the country they currently often have to go through another assessment; unsure of how much money they will be allocated or the type or quality of support they will receive. This acts to disincentivise individuals from moving and can lead to social exclusion if they are not able to move close to where their families live, for example.

**Personalisation**

1.19 Personalisation for people with complex needs should be taken forward and understood in the wider context of being more than personal budgets. Personal budgets work for many however they will not work for all. Therefore personalisation must be about an approach to commissioning and service provision that puts the individual at the centre. Where there is a known, allocated amount of money for an individual’s support which they are able to spend how and where they choose.

1.20 Personalisation must be about coproduction between the individual and their wider circle of support to design and deliver their package of care. This ties in closely with the Government’s Big Society agenda and Any Qualified Provider reforms within the health system. It should not, however, be used as a cost cutting tool by local authorities who are finding their budgets are being squeezed. The White Paper, therefore, needs to this and safeguard against it as the Government strives for its target of everyone having a personal budget by 2013 (Department of Health 2010).

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90 Kings Fund, April 2011, http://www.kingsfund.org.uk/topics/social_care/
92 Personal budgets for all and more breaks for carers
http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_121690
1.21 There is a raft of guidance available around personalisation, particularly through the Think Local Act Personal umbrella group, which Turning Point supports. This has produced guidance and a tool for providers and commissioners to learn from innovative practice in commissioning and delivering personalised services. This guidance is particularly helpful for local authorities to consider current practice and to identify areas that need improvement and develop plans for change.

INTEGRATION

1.22 As mentioned previously the idea that health and social care, along with housing, employment and other benefit systems, exist independently of each other is fundamentally flawed.

1.23 There has been a real opportunity recently, with the changes being proposed in the Health and Social Care Bill, to integrate services around the individual. This, unfortunately, has not been the case in any tangible way. There remains three separate outcome frameworks (NHS, Social Care and Public Health), although effort has been made to link them in places; care and support budgets remain separate; and commissioning remains disjointed in the majority of areas. This not only wastes resource but misses an opportunity to achieve the cost savings integration can provide.

1.24 The Government’s commitment to promote integration between health and social care is absolutely crucial if the future system is to be more efficient; continue to drive up quality and achieve greater value for money for people with social care needs, particularly those with multiple or complex needs. This is also critical for transition periods, not only young people to adult but increasingly adult to “older people”.

1.25 This approach to integration which is much needed, must be coupled with incentives if it is going to be more than just rhetoric. The cost benefit case has been made repeatedly that integrated services achieve better outcomes and greater value for money. This now needs to be translated into action. Without it there will continue to be unmet need; duplication of effort; and confusion for individuals who may not understand why a proportion of their service is no longer “free” or why multiple teams are providing it.

October 2011

Written evidence from The Relatives & Residents Association (SC 32)

SUMMARY

1. The Relatives & Residents Association (R&RA) speaks up and speaks out on behalf of older people in care homes. It is the only national charity for older people providing a daily helpline which concentrates entirely on residential care for this age group.

2. The Association has a number of comments on the issues facing the government as it prepares its Social Care White Paper, and makes recommendations for consideration by the Government before the White Paper is published. Recommendations concern:
   — transition arrangements from the current funding system to the new system;
   — the impact of any future funding system on the ability of individuals to exercise a real choice of care homes;
   — greater transparency on decisions concerning eligibility for social care support;
   — advocacy/workers to represent the interests of vulnerable older people;
   — developing a whole system approach to care provision for older people; and
   — financial viability of care homes.

ABOUT THE RELATIVES & RESIDENTS ASSOCIATION

3. The Relatives & Residents Association (the R&RA) is a small charity which was founded in the early 90s to campaign for a better quality of life for older people living in care homes and other types of “long-term care”. Dorothy White OBE, our founder started her career in the 1940s, as a young civil servant, working with Nye Bevan to set up the NHS. From her own experience with her mother in a care home, she had come to realise how important it was to provide a voice for those who, all too often, were unable to represent their own interests because of their frailty and dependence.

4. By using the unique perspectives of relatives and residents, we work in harness with others to help improve service and standards. We also try to influence policy and practice by reflecting the experience of our members and callers who use our daily Helpline and thus can make evidence based comments on the case we make, the research and training we carry out and the policies we advocate.

5. We provide support and information through our Helpline which operates every weekday and helps older people and their relatives make better informed decisions about looking for a home, their rights under DH and other guidance and regulations, and the benefits and standards they should expect. All too often, people are

93 More information on Think Local Act Personal can be found here:
http://www.thinklocalactpersonal.org.uk/
totally confused about the labyrinthine system and in particular, by how care is organised and what elements of the cost have to be met by whom.

6. We also act as a listening ear to help support families and individuals at what is often a time of crisis and trauma for them, when it becomes apparent that a partner, parent or friend can no longer live at home. We also help them when there are difficulties and complaints about the standard of care and often act as brokers between the relative/concerned individual and the care home.

7. Most of our Trustees have worked in the sector and have also had their own experiences of their close relatives in residential care. We have a small core staff, supported by experienced and dedicated volunteers. In all its activities, the R&RA's emphasis and mission is to put the needs of the resident first.

8. Our comments are based on our Helpline service and our activities, including training, research and feedback about the reality of life in care homes for older people.

### Practical and Policy Implications of the Government's Plans for Funding Social Care

9. R&RA agrees with Dilnot that: “The current system is confusing, unfair and unsustainable.” This is certainly the experience of callers to the R&RA helpline who are all too often given incorrect or misleading information from local authorities and/or the NHS. Some carers and spouses are frightened that councils will take away their homes, while others are shocked that possession of capital over £23,250 can mean that social services departments are unwilling to provide any assistance for their relatives including those with severe dementia and other complex medical conditions.

### Current Care Home Residents

10. It is disappointing that the Dilnot report has little to say about the needs of people who are now living in care homes or who will be admitted for residential or nursing care in the interim period before changes to the funding system is introduced.

11. It is unclear what the effect of the perceived advantages of a cap on payments and the increased threshold for capital will have for those planning their care needs and could result in delayed assessments and admission to care homes even where admission could be in the best interest of the individual concerned. While R&RA agrees with the view in the Dilnot report, "that, when the scheme is introduced, certain groups could already be deemed to have met the cap. These could include all those who have already been in residential care for two years."); introducing the Dilnot recommendations overnight will likely result in increased short-term pressures on the health and social care systems including delayed hospital discharges. We could also see a surge in the numbers requiring assessment, potentially threatening lives and well-being of those whose care needs can only be met in a care home.

### Recommendation

Government should consider the timing and transition arrangements from the current funding system to the new system to avoid putting at risk the health and well-being of future care home residents.

### Top-ups

12. It is also disappointing that Dilnot overlooks the existing funding pressures on the relatives of those living care homes and the lack of transparency by local authorities to clearly publish the amounts they are prepared to pay for long-term care. As the costs of around two-thirds of care home residents are met in whole or in part by local authorities, they have considerable leverage to drive down the amounts they are prepared to pay providers. By driving down fees, relatives are put under financial pressures and as the amount of top-up payments relatives are regularly being asked to pay are constantly increasing. This is all too often happening unlawfully. [We can provide evidence of LGO investigations criticising local authority practice in this area.] This practice also removes choice from relatives who are unable to pay the top-up. Some callers to the R&RA helpline, many of whom are in their 80s and 90s feel bullied and manipulated and become extremely upset because the fees for a local care home, or their preferred care home are above the rate the local authority are prepared to pay. They themselves often have limited resources and are bewildered about the rules and the frequent changes. A top-up of £20 per week in 2011 becomes £40 or £50 or more in 2011 and they simply cannot continue without hardship and/or guilt.

13. The unfortunate practical implications of the Dilnot report is to accept and endorse the current practice of ever-increasing top-ups and the failure of both central government allocations and local authorities to take into account the rights of residents for a stability and continuity, as well as the Directions on Choice of Accommodation. Disregarding these means that people are regularly removed from a good and familiar environment at a time when many residents are at the ends of their lives and have little capacity to prevent their displacement.
Recommendation

The future funding system must consider the impact on the ability of individuals to exercise a real choice of care homes. It should also take account of the Directions on Choice of Accommodation and consider how far commissioning practice is leading to diminishing choice of care homes for families and their older and infirm relatives. Any future funding system must also take account of the human rights of older people in residential care and ensure that they are no longer moved arbitrarily in this way.

Eligibility Criteria

14. The recommendation in the Dilnot report that until the current assessment system is replaced, the threshold for provision of social care should, at a minimum, be set at “substantial” could result in councils misapplying guidance for assessments to ensure that numbers of people with assessments result in “moderate” assessments, denying people the support they need. Those councils remaining whose minimum criteria is set at “moderate” will have a green light to set their criteria at a higher level rather than from their own locally assessed needs and policies.

Recommendation

Councils must be more transparent and clear with relatives about how conclusions are reached about a person’s eligibility and ensure that there are adequate routes for challenge and appeal. At the least, councils should be asked to monitor the outcome of all assessments so that an assessment can be made nationally about the potential impact of the new system.

Living Costs

15. Dilnot proposes that people should contribute a standard amount to cover their general living costs in residential care—£7–10k per year. People with the means can choose to pay more, but in the knowledge that any “top-up” payments won’t count towards the “cap” and won’t be funded by the state once they are eligible for full state support. Top-up payments have already been discussed in this submission, but the general public is unaware that the revised funding system will not cover general living costs. It is arguable whether the most vulnerable individuals should be asked to pay for food and accommodation in any case, and it is unclear that general living costs can or will be met wholly from state benefits, bearing in mind that the average state pension is £5K.

16. The argument for charging extra for food and accommodation seems illogical and detrimental to the well-being of potential residents. It suggests than diet and accommodation are optional extras, rather than intrinsic to good quality care. Are some residents to be able to decline food and allow their own to be delivered or omitted, or possibly purchase them elsewhere for better value? Over 70% of care home residents have some form of dementia, Parkinson’s, heart or other disease, where diet, nutrition and proper feeding regimes—and their monitoring—are essential ingredients of their care and support. Some care homes spend less than £11 per week on food, have low staff ratios and pay the minimum. What safeguards will be in place to ensure value for money for those who cannot speak for themselves?

Recommendation

R&RA strongly disagrees with this premise R&RA and considers that care costs should be funded by general taxation to avoid the inherent unfairness of means-tested systems of any kind. Apart from the fact that the current system militates against quality provision by pushing public sector costs down, this also has the effect of reducing investment in a properly trained workforce with a decent career structure. In addition, the costs which accrue to local and health authorities in assessment, reassessment and border disputes need to be considered.

Any other system risks the continuation of an unfair system which discriminates against older people, where there is an imperfect market and ill-informed “consumers”. This coupled with the prospect of an enhanced role for the insurance industry, which has a dismal record in this area, both here and in the USA, gives us little comfort for the future.

Advocacy

17. Research carried out by R&RA shows that up to Up to 40,000 older people living in care in England are at risk of social isolation. The findings are the result of a two-year government-funded research project. They show that at least 8% of older people in care in England are either without kith or kin or have no contact with them. Among other findings R&RA found that neither central government nor social services departments have national guidelines or strategies in place to support elderly in care who may be socially isolated. This effectively denies choice to a substantial number of people about which home they should live in, how much (if any) top-ups should be payable, and how they should be cared for.
Recommendation

All older people who need personal care (in the same way as children in need) should have someone appointed either by their local authority or health authority or under their aegis, to ensure that older people who need care are properly represented and protected. If advocates/workers are to be appointed, they need to be properly accredited and have access to appropriate records as well as properly defined responsibilities to safeguard the welfare of their “client”. These could be invaluable when decisions are made about placement in a care home and how funding, including the need for top-ups will be met.

The Scale and Implications of Existing Variation in Access to and Charges for Social Care in England

The Barriers Faced by Recipients of Social Care when they Wish to Relocate to Another Area, particularly with regard to the Portability of Assessments

18. R&RA is well aware from callers to our helpline that people find the charging system utterly bewildering, and are astonished that charges of neighbouring authorities can vary so wildly. The variation in charges can lead to demands for increases in top-up payments, or placing individuals in a care home that cannot meet the needs of residents or placing the person in a home too far distant for relatives to visit.

19. The key priority for LAs should be the wellbeing of people who use services, but all too often, priority is given to disputes about who should pay, who should carry out assessments and whether a person is ordinarily resident in one area or another. Too many callers find themselves in a situation where care is not provided at all while disputes are ongoing which is clearly in breach of the 2010 Directions given by the Secretary of State.

20. Callers to the R&RA helpline report disputes arising following review of continuing care where continuing care funding is withdrawn and the council are unwilling to meet the costs of the care home previously funded by the NHS. We have also have reports where neither the council nor the NHS will meet care costs while disputes are ongoing about whether continuing care criteria have been met. In one particular case, the care home felt obliged to serve a notice to quit as the bills were not being paid and the family did not have the resources to cover the costs in the interim.

21. Key to successful implementation of standardised eligibility criteria for service entitlement will be acceptance of the standardised eligibility criteria by councils which may require the force of primary legislation. There will also need to be transparency about the application of the criteria, accountability and systems to ensure compliance.

22. Barriers that face social care recipients who wish to relocate to another area are not confined to the lack of portability of assessments, but include councils lack of co-terminosity with PCTs, reorganisation of the health and social care structures, lack of expertise of commissioners about the needs of very vulnerable older people, lack of a shared vision across health and social care services and shortages of specialist providers in care of older people.

Recommendation

Directions on eligibility criteria should include eligibility for NHS continuing care and both the NHS and councils should be required to explain how decisions about eligibility have been made. Individuals and their families should have a statutory right to challenge conclusions reached about assessments and be provided with an independent assessor where disputes arise. (see above recommendation under “Advocacy”).

Economic Regulation of the Social Care System including a Proportionate Failure Regime that can Mitigate Against the Failure of Social Care Providers

23. The current regulatory regime has clearly failed the residents of Southern Cross, failing as it did to recognise the financial risks the owners had taken in the years leading up to its demise. The finances of other larger companies are also at risk. A study carried out by Unison shows that the second largest care provider, Four Seasons, is also in severe financial difficulties and it seems others may well follow.

24. Clearly Government needs to take steps to secure continuity of care through market management which does not leave taxpayers to pick up the bill. Given the nature of the service carried out, residents cannot be left without care. However, if a market is to exist in social care provision, then adequate steps must be taken to hold companies to account for investment decisions that could potentially place at risk the continuity of care of our most vulnerable citizens.

Recommendation

Regulations (see Regulation 13 of the Act) already include a requirement to ensure that the finances of care homes are viable. Despite the fact that this regulation has been extant for some time, it is clear that neither CSCI nor CQC took it sufficiently seriously. As a result, in order to be effective and properly informed and equipped, the regulator must be financed to employ and have ready access to the appropriate expertise.
In addition, R&RA considers that the status of the care home in law needs re-examination. It is unacceptable that at present residents are treated as though their environment is analogous with a corner shop. The owners can give one month’s notice to quit or stop trading for whatever reason they choose. There are no sanctions or deterrents. Considering that most homes have been maintained and subsidised by the public sector over the past 30 years, it seems unfair that the implicit contract to give people a stable and caring home at the end of their lives can be so easily breached.

This means that people at the end of life should never be moved unless it is in their best interests. The normal expectation in the average to good care home is that residents remain there, cared for by known carers in a familiar environment.

In addition, if for any reason the provider has failed in the duty of care, resulting in the breach of regulations, the working assumption must be that the residents are not disrupted and remain undisturbed. Unless the environment is deemed damaging or unsafe, the care workers should remain, properly supervised and managed by the local authority or health authority or the regulator. The ownership of the property should not be the main determinant of what happens to vulnerable people at the end of their lives, many with terminal conditions. In the same way as others who have broken their contracts, there need to be clear sanctions and penalties for those who have betrayed the trust of those they were pledged to care for.

**The Practical and Policy Implications Of The Government’s Stated Commitment to Promote Integration Between Health and Social Care Services**

25. It remains to be seen whether this is empty rhetoric or a real opportunity to make a qualitative difference to care provision to those individuals whose needs can only be met through successful collaboration of NHS and social care providers. It does not seem credible that in this day and age, too many vulnerable individuals are subject to bureaucratic bungles, buck passing, or allowed to slip through the widening crevasses between the NHS and local social services departments. R&RA, like the Kings Fund, have no confidence that the proposed structure will work.

26. For at least the last 20 years different government have exhorted integration. They have been many statements of intent, strategies, initiatives, and even incentives. These have included countless top-level meetings of expensive chief and senior officers often with little to show for their activities. The R&RA has had some worrying examples: one of the latest is that of an 85 year old with severe mental illness (and family living abroad), who was moved from hospital to a nursing home where the weight loss suffered was 20 kilos. This person was subsequently re-admitted to hospital weighing about 6 stone. When ready to go to a more specialised nursing home, the local authority and health authority could not agree about the fee, despite the fact that the current and extended stay in hospital was costing more than double the amount in dispute.

**Recommendation**

Government needs to ensure NHS and social care providers are given incentives to provide preventative and re-ablement services and should also require providers to work towards closer integration. Health and Wellbeing boards should be given powers to oversee integration with progress (or lack of) reported to the affected populations.

Those with a named person or advocacy role could also affect practice if they were enabled to report directly to those planning/overseeing integration practice on a regular basis.

**October 2011**

**Written evidence from the National AIDS Trust (SC 33)**

**Summary of Recommendations**

The Committee should recommend the Government continues to provide separate funding for HIV social care beyond 2014–15.

Funding for HIV social care should continue to be increased year-on-year to ensure that there are sufficient funds to provide support for the increasing numbers of people living with HIV.

The BPS, BHIVA and MedFASH “Standards for psychological support for adults living with HIV”, due to be launched in November, should be considered by all Local Authorities commissioning social care and integrated into mental health and social care services.

The Committee should recognise the important preventative value of social care for people living with HIV, and recommend that this is given due consideration by Local Authorities when making decisions on service provision.

Assessment criteria for eligibility for social care should consider the impact of fluctuation and the cumulative impact of multiple, lower-level symptoms on people living with HIV.
The need for continued specialist support services for people living with HIV and/or HIV training for generic social workers should be recognised by the Committee.

If the recommendation in the Dilnot report on a national eligibility threshold is implemented it is important that the threshold takes into account fluctuating symptoms and the unique stigma and discrimination people living with HIV face.

Local Authorities should continue to use the “HIV/AIDS Support” funding to provide social care support for people living with HIV, including supporting voluntary sector organisations in providing open-access information and support services.

Personal budgets and direct payments should be made available to people living with HIV.

The Government must ensure that health and social care services for people with HIV, which are commissioned by different bodies and at different levels are integrated effectively, and that the concerns of people whose treatment is commissioned by the NHSCB are properly considered by Health and Wellbeing Boards.

A. INTRODUCTION

1. NAT is the UK’s leading charity dedicated to transforming society’s response to HIV. We provide fresh thinking, expertise and practical resources. We champion the rights of people living with HIV and we campaign for change. All our work is focused on achieving four strategic goals:
   — effective HIV prevention in order to halt the spread of HIV;
   — early diagnosis of HIV through ethical, accessible and appropriate testing;
   — equitable access to treatment, care and support for people living with HIV; and
   — eradication of HIV-related stigma and discrimination.

2. This submission addresses only those areas where we have relevant points to make on the basis of our work and which have particular relevance for people living with HIV. It also raises additional issues which we feel are important and should be considered by the Committee.

3. NAT welcomes the Committee’s inquiry into social care. We note the particular focus of the inquiry into those 65 years of age and older but would urge the Committee to also address the social care needs of the more than ten million people with long term conditions, impairments or disabilities, including HIV.94 HIV is a long term condition (based on the Department of Health definition) and under the Equality Act 2010 is defined as a disability.

B. FUNDING FOR SOCIAL CARE FOR PEOPLE LIVING WITH HIV

4. Funding for social care for people living with HIV has undergone significant changes over the last 18 months. An outline of these changes is necessary to understand the challenges HIV social care currently faces.

5. From 1989 until June 2010 HIV social care was funded via a ring-fenced grant called the AIDS Support Grant (ASG). The amount given to each Local Authority was calculated using a formula which based on the prevalence of HIV, and included a weighting for women and children affected by HIV.

6. The ASG was used by Local Authorities to provide a range of services for people living with HIV, including counseling, peer support, support for carers, personal care, respite care, and residential care. It was also used to provide HIV training for staff.95

7. The ring-fence around the ASG was removed in June 2010. Subsequently, in the Comprehensive Spending Review in October 2010, the ASG was abolished. However the Department of Health and the Department for Communities and Local Government recognised that the funding allocated to each Local Authority for social care for people living with HIV needed to be kept separate from the main body of social care funding within the Formula Grant. There is now a specific funding line for “HIV/AIDS Support” within the Formula Grant so each Local Authority is aware of how much funding they have been allocated to provide social care service to people living with HIV in their area. This funding is set to continue until 2014–15 with an increase each year. We welcome this increasing level of funding which is necessary as the number of people living with HIV in the UK is set to top 100,000 by 2012.

8. Currently neither the DH nor the CLG are monitoring how Local Authorities are spending the money allocated under the “HIV/AIDS Support” funding line. This lack of scrutiny is particularly worrying in the current financial situation and NAT is concerned about whether Local Authorities are spending their allocation on meeting the social care needs of people living with HIV in their area. We are currently undertaking a survey of all Local Authorities that receive “HIV/AIDS Support” funding to ascertain how the money is being spent. We will send the Committee a copy of the results of this survey when they are available.

94 Office for Disability Issues, HM Government website:

Recommendation: The Committee should recommend the Government continues to provide separate funding for HIV social care beyond 2014–15.

Recommendation: Funding for HIV social care should continue to be increased year-on-year to ensure that there are sufficient funds to provide support for the increasing numbers of people living with HIV.

C. Importance of Social Care Support for People Living With HIV

9. Over the last 30 years the social care needs experienced by people living with HIV have changed, but they have not gone away and they remain substantial.

10. NAT recently carried out a survey of healthcare professionals working in HIV. The survey revealed that the majority of respondents referred a patient to social care between once a week and once a month.96 This is a strong indicator of the continuing high level of need for social care support for people living with HIV.

11. There is a higher prevalence of mental health problems amongst people living with HIV than within the general population.97 These problems are often associated with stigma, disclosure, the shock of diagnosis, and social isolation. A recent UK study found that a high proportion of people living with HIV report a range of symptoms caused by the psychological burden of living with HIV including lack of energy, difficulty concentrating and feeling irritable and nervous.98 This suggests widespread psychological/emotional support needs.

Recommendation: The BPS, BHIVA and MedFASH “Standards for psychological support for adults living with HIV”, due to be launched in November, should be considered by all Local Authorities commissioning social care and integrated into mental health and social care services.

12. People living with HIV also commonly experience social care needs relating to poverty and associated issues. People with HIV are disproportionately affected by poverty—between 2006 and 2009 one in six of all people with diagnosed HIV had to approach the Hardship Fund (a charitable fund providing emergency cash support for urgent cases of need) for assistance. On average their income after housing costs was only £42 per week.99 Poverty related needs were the most frequently cited support needs in NAT’s healthcare professional’s survey; 64% of respondents cited housing-related issues, 35% cited benefits advice, 31% cited financial problems, 30% cited immigration and 20% cited childcare or family issues.100

13. Social care for people with HIV makes a significant difference to how well people manage their condition. In our survey of healthcare professionals the majority stated that social care helped their patients, in coping with diagnosis, adhering to treatment, in psychological and emotional well-being, and in meeting physical care needs.101

14. A key benefit of social care is support in adherence to medication.102 Evidence shows that people with depression are less likely to adhere to their HIV treatment. People with HIV who adhere to their treatment and so achieve an undetectable viral load are extremely unlikely to pass HIV on to sexual partners. On the other hand, those who do not adhere to treatment see viral load increases which make them more likely to transmit HIV.103

15. It is estimated that one HIV transmission in the UK results in healthcare costs of between £280,000 and £360,000,104 and this does not take account of associated social and economic costs or costs relating to any other people that person may pass HIV on to. Healthcare professionals responding to NAT’s survey cited practising safer sex as one of the benefits of social care for people with HIV.105 Support in coming to terms with diagnosis and in disclosure of status, as well as in improved mental and emotional well-being, are all linked to safer sex. Good social care for people with HIV is part of good HIV prevention—failures in social care can bring high costs as a result of increased HIV transmission.

16. Poor adherence can also result in treatment failure and serious ill-health which cost far more both in terms of the drugs needed and in terms of inpatient care, and can have a significant impact on an individual’s health and long-term prognosis.

96 NAT, The impact of social care support for people living with HIV: the results of NAT’s snapshot survey of healthcare professionals, 2011.
97 NAT, Psychological support services for people living with HIV, 2010.
99 NAT and THT 2010 “Poverty and HIV 2006–2009”.
100 NAT, The impact of social care support for people living with HIV: the results of NAT’s snapshot survey of healthcare professionals, 2011.
101 NAT, The impact of social care support for people living with HIV: the results of NAT’s snapshot survey of healthcare professionals, 2011.
103 NAT, HIV treatment as prevention, 2011.
104 Estimates from the Health Protection Agency.
105 NAT, The impact of social care support for people living with HIV: the results of NAT’s snapshot survey of healthcare professionals, 2011.
17. The preventative value of social care support, as highlighted in the Government’s white paper, *A Vision for Adult Social Care: Capable Communities and Active Citizens*, is well illustrated by the positive impact of social care on people living with HIV. It is important that the value of social care for people living with HIV, including the low-level interventions such as those provided by voluntary sector organisations are fully recognised in the Committee’s inquiry.

**Recommendation:** The Committee should recognise the important preventative value of social care for people living with HIV, and recommend that this is given due consideration by Local Authorities when making decisions on service provision.

D. ACCESS TO HIV SOCIAL CARE AND VARIATIONS IN CARE

18. Research suggests that there are significant variations across the country in social care services provided for people living with HIV, and people’s ability to access these services.\(^ {106} \)

19. NAT’s survey of healthcare professionals found a 50% split between respondents whose patients have experienced problems accessing social care and those who have not, suggesting that the provision and availability of support is patchy. There were also indications of variations in terms of the availability of specialist support, with some respondents able to refer patients to specialist social workers and others commenting that “there is no such thing as HIV specific social care support”.\(^ {107} \)

20. In addition to variations between services, people living with HIV also face increasing barriers to accessing services. One of the current trends in social care provision which is significantly impacting on people with HIV’s ability to access the support they need is that of tightening eligibility thresholds.

21. A survey carried out by Community Care in 2010 found that three-quarters of councils only met critical or substantial care needs under the Fair Access to Care Services (FACS) guidance. This was expected to rise to 80% by 2011 under plans to tighten thresholds by councils currently supporting people’s moderate care needs. This represents a sharp decline in provision from 2006, when 53% of councils supported people with moderate needs.\(^ {108} \)

22. Early indications are that people living with HIV are not reaching the level of need necessary to access social care support, despite having considerable social care needs which impact on their health, quality of life and potentially on public health. This was highlighted by healthcare professionals in NAT’s recent survey. One comment indicative of the view of many was: “Social care funding is very restricted and not everyone fits the criteria—even though they do need help.”\(^ {109} \)

23. The fluctuating nature of the symptoms experienced by people living with HIV also makes it harder for people to reach the required eligibility threshold to access care. The majority of respondents to NAT’s recent survey of over 250 people living with HIV stated that their symptoms fluctuated over time. Those who did experience fluctuating symptoms were more likely to say that their symptoms “significantly affected” their daily lives.\(^ {110} \) The cumulative effect of a number of fluctuating symptoms should not be underestimated; they cause real distress to people, and place significant barriers to work, daily living and social participation. However it is questionable whether the pressure to save money through the rigorous application of ever tightening eligibility criteria will allow the severe impact of these fluctuating symptoms to be fully taken into account in assessments.

**Recommendation:** Assessment criteria for eligibility for social care should consider the impact of fluctuation and the cumulative impact of multiple, lower-level symptoms on people living with HIV.

24. People living with HIV also face problems around stigma and discrimination and it is important that these are taken into account in eligibility assessments. NAT’s previous research into the ASG showed that a number of Local Authorities applied a different eligibility threshold for people living with HIV because they felt that the stigma and discrimination faced by people was unique to HIV and they needed specialist support services. They were able to do this because the ASG was a separate ring-fenced grant.\(^ {111} \)

**Recommendation:** The need for continued specialist support services for people living with HIV and/or HIV training for generic social workers should be recognised by the Committee.

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\(^ {107} \) NAT, *The impact of social care support for people living with HIV: the results of NAT's snapshot survey of healthcare professionals*, 2011.

\(^ {108} \) Jeremy Dunning, “Councils to deny social care support to all but most needy”, *Community Care*, Wednesday 15 September 2010 (http://www.communitycare.co.uk/Articles/15/09/2010/115321/councils-to-deny-social-care-support-to-all-but-most-needy.htm)

\(^ {109} \) NAT, *The impact of social care support for people living with HIV: the results of NAT’s snapshot survey of healthcare professionals*, 2011.

\(^ {110} \) NAT, *Fluctuating symptoms of HIV: Findings of an anonymous online survey conducted by NAT*, 2011.

\(^ {111} \) We anticipate our current research will reveal this and as stated above we will send the Committee a copy of the report when it is published. Expected publication date: early 2012.
25. The Dilnot report recommends that eligibility criteria should be set at a standardised national basis to improve consistence and fairness across England. It recommends that the threshold, in the short term at least, should be “substantial”.

**Recommendation:** If the recommendation in the Dilnot report on a national eligibility threshold is implemented it is important that the threshold takes into account fluctuating symptoms and the unique stigma and discrimination people living with HIV face.

26. It is important that when assessing against thresholds Local Authorities are encouraged to take account of wider issues such as stigma and discrimination which may make it harder for people to access help elsewhere, the potential impact on public health of not providing social care support, and the preventative value of social care support for people.

27. It is also important that Local Authorities use the funding they have been allocated through the “HIV/AIDS Support” funding line to make sure that the social care needs of people living with HIV in their area are met. One way in which this can be done is through funding local voluntary and community organisations to provide open-access information and support, the availability of which is not based on eligibility assessments and which is targeted at hard-to-reach groups such as black African communities who are disproportionately affected by HIV and experience greater health inequalities generally.

**Recommendation:** Local Authorities should continue to use the “HIV/AIDS Support” funding to provide social care support for people living with HIV, including supporting voluntary sector organisations in providing open-access information and support services.

E. PERSONALISATION OF CARE

28. The personalisation of social care has the potential to be of particular value to people living with HIV, as it will allow care to be tailored to meet their unique needs. For example it will enable care to take account of the impact of stigma, discrimination and fluctuating symptoms. It is important that the potential of the personalisation agenda to meet the needs of marginalised groups is not compromised by a narrow interpretation of eligibility criteria aimed at saving money.

**Recommendation:** Personal budgets and direct payments should be made available to people living with HIV.

F. INTEGRATION BETWEEN HEALTH AND SOCIAL CARE SERVICES

29. NAT believes that improved integration between health and other services such as adult social care, mental health services, disability services, housing, etc, is important in providing a better overall level of care to the patient. This is particularly relevant for people living with long term conditions such as HIV where the patient requires support from a wide range of services on an ongoing basis.

30. Integration of health and social care services has the potential to realise the preventative value of low-level social care interventions. Greater integration will ensure that those commissioning services properly consider the impact of decisions around social care on individual and public health. As noted above social care helps ensure people adhere to treatment. If they adhere to treatment they are less likely to become ill and cost the NHS significant amounts of money in in-patient and emergency care. Adherence also saves considerable sums by reducing infectiousness and therefore potentially reducing transmission.

31. However, we are concerned that under the new NHS structures, integration will become harder for HIV treatment and care. HIV treatment will be commissioned by the NHS Commissioning Board (NHSCB), wider secondary care for people living with HIV will be commissioned by CCGs, and public health and their social care will be commissioned by Local Authorities. This risks fragmentation of services and may make it more difficult for health and social care services to work together to meet the needs of people living with HIV, unless specific steps are taken to integrate services.

32. Health and Wellbeing Boards will be central to NHS integration of services but the NHSCB will not be routinely represented at all Health and Wellbeing Board meetings—the result may well be the sidelining of concerns of people whose treatment is commissioned by the NHSCB, such as people living with HIV. The Government has failed to provide adequate reassurance on this point; the proposed integration between health and social care will not be effective for conditions such as HIV without a proper consideration of this issue.

**Recommendation:** The Government must ensure that health and social care services for people with HIV, which are commissioned by different bodies and at different levels are integrated effectively, and that the concerns of people whose treatment is commissioned by the NHSCB are properly considered by Health and Wellbeing Boards.

*October 2011*
Written evidence from Anchor (SC 34)

Background—Anchor

1. Anchor is a not-for-profit organisation with more than 40 years’ experience of helping older people. We are England’s largest not-for-profit provider of sheltered housing for rent as well as England’s largest not-for-profit care home provider. We provide great places to buy or rent as well as care and support services, including:
   — Almost 700 retirement housing schemes.
   — Property management services for leaseholders at 230 estates.
   — 96 care homes, including two specialist dementia homes.
   — Almost 1,000 integrated care and housing properties.

2. We are grateful for the opportunity to respond to the Health Select Committee’s inquiry into social care.

3. We would preface our comments below with a general point about the need for the Government to take a more joined-up approach to older people’s issues. Anchor is campaigning for the appointment of a dedicated minister for older people, attending Cabinet, to ensure all polices which are developed are future-proofed for demographic change.

4. More than 100,000 people have signed the petition and an Early Day Motion on the subject has been signed by 74 MPs, from all the major parties. The campaign is backed by organisations including the National Housing Federation, the English Community Care Association and a host of other specialist bodies.

Key Issues

The Government’s plans for funding social care, and the recommendations made by the Dilnot Commission and the Law Commission

5. We are supportive of the proposals of both the Dilnot Commission and the Law Commission. Together, they present a significant step forward in clarifying the relationship between the individual and the state and simplify the legal framework.

6. The findings of the Dilnot Commission on the Funding of Care and Support, published this summer, must be acted upon. Andrew Dilnot’s recommendations represent the most sensible, considered and practical response in many years.

7. It is crucial that a White Paper on the future of care funding is published by Easter 2012 and that legislation on this issue is included in the subsequent Queen’s Speech. This is essential if we are to tackle the short term funding crisis, create a sustainable long-term system for the future and, crucially, begin educating the public about the realities of funding care in later life.

The scale and implications of existing variation in access to and charges for social care in England

8. We agree with the assertion by the English Community Care Association that the degree of regional variation in care is unacceptable and we are concerned by the differences in funding at local authority level.

9. We believe there must be an honest conversation about the cost of care. Local authority funding has declined in real terms at a time when demand is increasing. Some providers will simply exit the market and care homes will close in some areas unless funding begins to reflect the true cost of providing the service.

Implications of the Government’s commitment to promote personalisation of social care, including personal budgets and direct payments

10. We support the move to personalised care and have been taking significant steps in Anchor to make this happen. However, debate about personalisation too often focuses solely on funding.

11. It is right that older people have more power to decide what services they want to receive and have greater control over paying for them. While we support personal budgets as a means to develop the personalisation agenda, the Government must do more to consider how best to protect vulnerable users.

12. Personalisation must not be allowed to simply become shorthand for increasingly limited funding, managed by individuals rather than local authorities. The social care workforce plays an indispensable role in supporting older people and this should be recognised and rewarded appropriately. The Government should further promote social care as a rewarding career choice and work with sector organisations to ensure that the workforce is equipped with the skills and training needed to provide the best possible care for older people.

The barriers faced by recipients of social care when they wish to relocate to another area, particularly with regard to the portability of assessments

13. Funding decisions should be made at a local level, with allocations in proportion to the local cost of care. A national framework should be used to calculate local funding allocations and ensure they are in proportion to the local cost of care, which can vary significantly across the country.
Economic regulation of the social care system including a proportionate failure regime that can mitigate against the failure of social care providers

14. Anchor would be deeply concerned about additional layers of regulation on top of the already expensive and labour-intensive approach faced by providers today. While we recognise the need to ensure older people are not let down by failings of the type experienced with Southern Cross, there has to be a recognition that the failure of some providers can be inevitable in a free market.

15. We echo ECCA’s view that current regulations already allow scope for economic regulation and further legislation is neither necessary nor desirable.

The practical and policy implications of the Government’s stated commitment to promote integration between health and social care services

16. The integration of health and social care is generally to be welcomed, particularly as people move along continuums of care. However there is insufficient evidence of it happening in every area and integration can be used by commissioners to push NHS standards, audits and guidance onto adult social care inappropriately.

17. While budgets continue to remain separate there is little financial incentive for commissioners to spend on preventative social care services which save money for the NHS. This is one of the many areas where a dedicated Minister for Older People could drive change.

18. It is also crucial that the role of housing is considered. There is a wealth of evidence demonstrating the relationship between appropriate housing and health in old age. Government spending on housing-related support results in savings to the public purse, primarily in health and social care costs, as a report for the department for Communities and Local Government found last year.

19. Yet there continues to be battles on the ground to secure funding for this crucial support and this is likely to continue while health and social care budgets remain separate.

20. While not strictly the focus of the Inquiry, it is also important to stress the artificial difference in the way planners treat applications for retirement housing and care homes. At Anchor, we believe that new housing for older people should be exempt from the planning restrictions that apply to mainstream housing. Care home developments are currently exempt from some section 106 requirements, but other accommodation for older people is not.

21. This is based on an outdated understanding of the nature of housing and care for older people. It fails to acknowledge that many people in retirement housing receive support or care, discourages the development of suitable housing and works against efforts to enable people to stay independent for longer.

22. With extra-care and new models of integrated housing and care blurring the boundaries between what is a care home and what is retirement housing, such a planning distinction seems increasingly archaic.

23. Extra-care developments, as with care homes, are also subject to an increasingly costly regulatory regime, which makes it more difficult for specialist housing to stack up financially than mainstream housing. Regulation of care services should be appropriate and proportionate to the service being provided. Couple the burden of regulation with the extra costs of regularly having to go to appeal in order to develop in the first place and it’s clear that developing older people’s housing can be an uphill battle.

October 2011

Written evidence from Investment and Life Assurance Group (SC 35)

1. INTRODUCTION

1.1 It is an accepted fact that we are living longer and that this will impact on the cost of care. Funding for social care has not increased by anywhere near enough to match demographic changes, now and into the future. The long-term care system has remained unchanged and it is imperative that the Government takes action now to reform the care system. We therefore welcome, in principle, the recommendations made by the Dilnot Commission and believe that these set out clear plans for a long-term and sustainable reform of social care.

1.2 The recommendations provide a much-needed examination of how to fund care in the future and an opportunity to break through the impasse and offer a funding system that provides clear entitlements to joined-up care and support where the responsibilities of the State and the individual are much clearer.

1.3 The current system makes it impossible for individuals to undertake any forward planning due to a lack of knowledge about care and how it is arranged, doubt about what to expect if and when care is required and the sheer complexity of the system. These proposals will help people plan ahead, manage finances and remove much of the uncertainty created by lack of predictability in care.

1.4 The proposals present opportunities for consumers to use financial products to pre-fund their share of care costs. ILAG welcomes the opportunity to assist in the development of a range of financial products that would support consumer choice and to propose ways in which existing products might be adapted to meet
future needs. This should include a reassessment of the legislative and regulatory environment to ensure that these act as an encouragement for consumers to act.

1.5 The proposed “partnership” model provides a balance between the individual and the State, helping to ensure that the highest costs do not fall on individuals and their families. The blend of a cap and an increased level of means-tested threshold will also help to ensure that those going into residential care would not have to spend most or all their assets on care costs.

2. 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

2.1 We agree that there should be a contribution partnership between Government and individuals, together with the recommendation that the means-tested threshold for people living in care homes should be raised from the current rate of £23,250 to £100,000.

2.2 Given the costs estimated from around £1.3 billion for a lifetime cap on the costs individuals pay for their care of £50,000 and around £2.2 billion for a cap of £25,000, it remains uncertain what amount the Government feels is acceptable given the current pressure on public spending. Nonetheless, ILAG supports the underlying principle for cost sharing.

2.3 Although the focus has been on a recommended £35,000 cap set between the suggested ranges of £25,000–£50,000, it is not widely understood that while everyone would also be entitled to universal disability benefits, additional contributions will be needed to cover general living costs up to £10,000 per annum placed on the individual. These general living costs are potentially two to three times what are indicated in the report’s recommendations and, hence, self-funders will still have a lot to pay once the cap is reached. Individuals may also seek alternatives to what the State (ie local authority) provides (eg a better quality care home).

2.4 The Commission also recommends that there should be a national eligibility and assessment framework to ensure consistency across local authorities in the way that individual’s needs are assessed. We support this. This new approach will allow individuals to take their assessment with them (no “post code lottery”) if they move from one local authority to another. However, interpretation could still vary significantly across different local authorities with differing budget constraints—consequently, the role of local authorities role in the success of the proposals will be key.

2.5 Local Authorities will be responsible for the proposed “substantial” assessment (some authorities are funding only “critical needs” whilst others fund preventative services for “low level needs”), and setting the figure for personal care costs which will used to meter the contribution towards the lifetime cap on social care.

2.6 When looking at the need for care, it is important that people are encouraged to stay in their own homes for as long as possible when they wish to do so. The system should cater for this.

2.7 There needs to be a clear definition of what the State will provide for which, in turn, can be linked with eligibility requirements for claims made through additional care-related products in the market.

2.8 Whilst there are few issues under the current (comprehensive) regulatory long term care environment, we have concerns that, in future, there may not be enough qualified care advisers to cope with a potentially greater number of people requiring advice and care.

2.9 At present, advice is often sought at a time of crisis and there are no mechanisms in place to drive people towards earlier provision. Although the quality of existing care advisers is very good, currently fewer than a quarter of self-funding individuals receive advice when going into care. It is possible that the implementation of the Retail Distribution Review might stimulate fee-based care advice.

2.10 Pre-funding for care is presently severely restricted by regulation due to its classification as investment business. The additional costs this brings to the industry have meant that it has not been attractive for insurers to offer pre-funded products which extend into the provision of care. This needs to be reconsidered if a market for pre-funded care products is to be developed and encouraged.

2.11 Many other products and features are potentially possible, including disability-linked annuities, equity release, last survivor cover, and adapting life, disability and savings plans (including a “Care ISA”) There could be a role for facilitation in the workplace, including care funding aimed at encouraging provision by children for themselves and/or their parents.

2.12 It is clear that there is a need for improved advice and education. Raising awareness of long-term care needs is essential, not least because many people may still expect that they will be looked after for free. There is a need to improve individuals’ understanding of what they will be required to fund themselves.

2.13 To persuade people to plan ahead the Commission calls on the Government to invest in an awareness campaign (perhaps coupled with work to encourage pension saving). ILAG supports this approach which should inform people of the new system and positively endorse the importance of planning ahead. Additional awareness could also be supplemented via the Money Advice Service website.
2.14 We support the Commission’s recommendation that local authorities should also encourage people to seek appropriate and reliable financial advice—either when approached for information about care and support services or when an assessment is completed.

2.15 Pre-funded long term care products aligned to State provision will be key to a successful public/private partnership. Insurers will look to a sustainable definition of when entitlement to cover arises in order for a partnership to achieve long-term success. It is noted that the Commission has called for a cross-party consensus and the criteria set out the Commission included “sustainable”.

2.16 There needs to be an assurance that funds invested by individuals into schemes are not lost if care is not ultimately required and could form part of an individual’s estate on death.

2.17 Following the recent changes to annuity rules for individuals reaching age 75, there is now a risk of a drawdown decline as the need to go into care increases with age. Flexible pension rules are needed to allow surplus funds to be redirected on a tax-advantaged basis into care home funding if required. Providers also need the flexibility to provide disability-linked annuities. This could be achieved by amendment to pension legislation.

2.18 Given that contributions to a pension scheme derive a benefit from tax relief to encourage participation, funding for care could also be encouraged by inclusion within the annual allowance. A long-term care ISA would also be a suitable tax incentivised savings vehicle.

2.19 Contributions might also be made via NEST to lower costs.

2.20 There will be differing interpretations of the triggers for provision of care; although the commission recommends “substantial” (in the short term), the interpretation of this will vary by local authority.

October 2011

Written evidence from Professor Les Mayhew and Dr Ben Rickayzen, Cass Business School, London

Recommendations Made by the Dilnot and Commission’s Report “Fairer Funding of Social Care”

1.1 This submission focuses on the practical and policy implications of the Government’s plans for funding social care, and the recommendations made by the Dilnot Commission.

1.2 We believe that whatever system is adopted it should not jeopardise movement towards the greater integration of health and social care.

1.3 We also believe that a system in which the cost of care should fall wholly on tax payers would not be fair. This would place a further burden on people that in future years will need to repay student loans, save for pensions, purchase a house and bring up families.

1.4 We strongly support the need for a portable and preferably uniform assessment system for different parts of the country. This would assist, for example, in the creation of a market for private finance products because entitlements, both state and private, would be aligned.

1.5 It is essential that any new system creates stable market-place private financial solutions that meet people’s needs and must provide the appropriate incentives to save for old age.

1.6 As well as point-of-need products such as immediate needs annuities and equity release, or pre-funded products such as long term care insurance or disability-linked annuities, a market place must be created for people on low means to encourage saving for old age.

1.7 The state can also help by reforms to the benefits system. Attendance Allowance for example is a universal non taxable benefit but the name is an anachronism and the benefit itself is poorly targeted.

1.8 We suggest that consideration should be given to merging Attendance Allowance with the state pension. Similar in concept to a disability linked annuity, it would provide a significant uplift in the value of the pension when older people become disabled, but it would also be taxable.

1.9 The Dilnot Commission’s recommendations are a step forward in terms of analytical rigour and therefore substantially more evidence-based than the White and Green Papers of the last Government. We support, for example, the argument that the individual must take more responsibility for funding their care but we disagree with the mechanisms.

1.10 Our own research using data from surveys such as ELSA demonstrates that today’s 65+ population is, for the most part, asset rich. It shows for example that approximately 80% of individuals could notionally afford to fund their social care for five years or more based on a combination of assets and income.

1.11 We question therefore why there should be a cap on care such that once care costs have risen above £35k a year the state will take over funding. If a person entered residential care this cap could be reached
Ev w84  Health Committee: Evidence

within two years, but would take longer if a person were cared for at home. This will greatly benefit the rich who could afford to pay more.

1.12 The Commissions’ argument is that a cap will protect individuals from the otherwise catastrophic costs of those people who need care for an extended period of years (the so called “tail” risk). In our response we suggest a fairer means of dealing with this issue.

1.13 The second key recommendation of the Commission is that, for those on low income or assets, the present means testing system would be extended to cover people with assets of up to £100,000. It is argued that this would create more certainty in the market place for insurance products as well as protect the very poorest.

1.14 However, we believe that the proposed reforms to the means test do not go far enough. The system will remain difficult for individuals to understand, particularly the component known as the tariff income rate which is an imputed level of income from a person’s assets.

1.15 Under the proposals, it is unclear how the value of private finance products such as disability linked annuities, or pre-funded insurance, would work for means testing purposes. This, and the complexities of tariff income, will have a limiting effect on private funding coming into the market.

1.16 The main problems we have with the Commission’s approach are therefore as follows:

(i) The cap is arbitrary and does not distinguish between people who have much more substantial assets (homes, financial assets etc.) and clearly favours the better off who should be expected to contribute more.

(ii) The operation of the cap requires that care is metered and that metering is portable. We believe that metering rules will be subjective and capable of multiple interpretations (eg people sourcing private care versus local authority care). Additional bureaucracy and an inspection system would be needed (unnecessary in our view).

(iii) We note that the £35,000 cap includes the notional cost of any informal care. Social workers will have to allocate notional packages of support on the basis of notional informal care provision with possible perverse consequences on the supply of informal care.

(iv) It should be a goal of any new funding system to incentivise people to save for their old age or to invest in financial products that pay out once care starts. By penalising savers the present means testing system does not do this and, without the appropriate reforms, it will cause people to save even less.

1.17 A general point about the Commission’s work is that it appears that other funding models were not appraised, which is unfortunate in our view. The recommended approach is a solution of sorts, but it seems to focus exclusively on the issue of catastrophic costs, regardless of the distributional consequences for people of different means and from different generations. As a result, we end up with a system that is “fairer” but one that is still not “fair”.

1.18 Beyond this we are concerned about the sustainability of the policy as care costs rise, more people ending up in care for longer (eg through increased prevalence of Alzheimer’s disease), and the commitment to the system from future governments. This could undermine attempts to develop a market for private sector products and therefore limit the amount of new money coming into the system.

1.19 Contrary to what the Commission believes, it is questionable whether the private sector will be able to develop and market financial products that are shackled by the complexities of the present means testing system. As a result of these proposals, we believe that the currently very small market for private finance products could actually shrink.

2. AN IMPROVED BASIS FOR A FAIR AND AFFORDABLE FUNDING SYSTEM

2.1 The following funding proposal has been developed by Cass Business School, details of which were published in 2010 in the Economic Journal (see bibliography). This research builds on earlier research carried out at Cass on the future costs of long term care and on the costs and benefits of systems adopted in other countries.

2.2 Our system has four features:

— A simplified system of eligibility for state support based on a simple combination of income and assets.
— Support that encourages savers and does not penalise them (the present means testing system would be scrapped).
— A graduated system such that if people de-cumulate their assets to pay for care the amount of state support increases.
— Fullest protection given to people on lowest incomes with few assets.
In our system, people assessed as needing care would be put in one of five bands A to E. The bands would be related to the amount of care each person could *notionally* afford based on their income and assets eg less than one year, greater than one year but less than two years and so on. People in band E would be able to afford up to five years of care on this basis.

2.3 A simple formula would enable self assessment and help with financial planning. Each band would attract different levels of state support. Levels are expressed as a percentage of the difference between the notional annual cost of care required and reckonable income. In our example, we have suggested 90% for band A, 70% B, 50% C, 30% D and 10% E but this can be varied.

2.4 Those with greater wealth would be un-banded and would not receive any support. However, assuming they live long enough, each person would move into a higher funding band as determined by in the rate at which their assets ran down. How it would work is given in Table 1.

2.5 Assume a particular individual’s state pension and other benefits is worth £10,000 per year and that the state sets the limit of state support for nursing care at £25,000 a year. For illustration, assume no other reckonable income. Based on the illustrative rates shown, a person in each band would receive the annual amounts shown:

Table 1

<table>
<thead>
<tr>
<th>Band</th>
<th>State support</th>
<th>Personal contribution</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>£13.5k (£25k–£10k) x 0.9</td>
<td>£1.5k</td>
<td>£25,000</td>
</tr>
<tr>
<td>B</td>
<td>£10.5k (£25k–£10k) x 0.7</td>
<td>£4.5k</td>
<td>£25,000</td>
</tr>
<tr>
<td>C</td>
<td>£7.5k (£25k–£10k) x 0.5</td>
<td>£7.5k</td>
<td>£25,000</td>
</tr>
<tr>
<td>D</td>
<td>£4.5k (£25k–£10k) x 0.3</td>
<td>£10.5k</td>
<td>£25,000</td>
</tr>
<tr>
<td>E</td>
<td>£1.5k (£25k–£10k) x 0.1</td>
<td>£13.5k</td>
<td>£25,000</td>
</tr>
<tr>
<td>Un-banded</td>
<td>nothing (£25k–£10k) x 0.0</td>
<td>£15.0k</td>
<td>£25,000</td>
</tr>
</tbody>
</table>

2.6 Under the present system about 22% of people would qualify for state support. Were the banding system to be adopted, we estimate that about 30.1% would get something. The main beneficiaries are people who just miss out under the present system and who may be forced to sell their homes to pay for care.

2.7 Our analysis shows that the 65+ population falls into two main groups, but by far the largest group is the un-banded category (ie notionally they could afford care for more than five years). Because of the levels of wealth accumulated by baby boomers, the number of people falling into the un-banded category will increase with time. This will help offset otherwise increasing costs to the state.

Table 2

<table>
<thead>
<tr>
<th>Band</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>29.9</td>
<td>26.3</td>
<td>21.1</td>
<td>15.9</td>
</tr>
<tr>
<td>B</td>
<td>2.4</td>
<td>3.5</td>
<td>1.6</td>
<td>2.1</td>
</tr>
<tr>
<td>C</td>
<td>2.8</td>
<td>3.0</td>
<td>2.4</td>
<td>1.8</td>
</tr>
<tr>
<td>D</td>
<td>2.6</td>
<td>3.6</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td>E</td>
<td>2.6</td>
<td>2.6</td>
<td>2.6</td>
<td>3.5</td>
</tr>
<tr>
<td>&gt;E</td>
<td>59.7</td>
<td>61.0</td>
<td>69.6</td>
<td>74.0</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Examples

2.8 Here are two examples: (a) Mrs White and (b) Mr Black. The assets and income of each varies—eg Mrs White owns a house and has a small occupational pension, Mr Black has more savings but no house or occupational pension. Table 3 shows how they would be supported under our approach in a consistent and fair way and the level of support provided.

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This example combines the cost of personal care and accommodation costs but it is easy to provide variants without accommodation costs.
2.9 Mrs White is banded D using the following formula:

\[
\text{Years of care} = \frac{\text{Assets}}{\text{Care cost} - \text{Income}} = \frac{\£46,000}{\£25,000 - \£11,600} = 3.43 \text{years} = \text{Band D}
\]

State support is therefore 0.3 x (£25,000-£11,600) = £4,020 and Mrs White’s personal contribution, in addition to her reckonable income of £11,600, is £25,000-£11,600-£4,020 = £9,380. A similar calculation puts Mr Black in Band A. He would receive state support of £11,480 and make a personal contribution of £4,920.

Table 3

<table>
<thead>
<tr>
<th>How State Support Would Be Calculated in Two Contrasting Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
</tr>
<tr>
<td>House</td>
</tr>
<tr>
<td>Savings</td>
</tr>
<tr>
<td>Sub-total</td>
</tr>
<tr>
<td>State pension</td>
</tr>
<tr>
<td>Occupational pension</td>
</tr>
<tr>
<td>Attendance allowance</td>
</tr>
<tr>
<td>Sub-total</td>
</tr>
<tr>
<td>Notional years of care afforded</td>
</tr>
<tr>
<td>Funding band</td>
</tr>
<tr>
<td>Public contribution</td>
</tr>
<tr>
<td>Personal contribution</td>
</tr>
</tbody>
</table>

2.10 At £25,000 this variant includes accommodation costs as well as personal care. However, both banding and level of support is unaffected if accommodation costs are initially deducted. For example, suppose accommodation costs are £10,000 and the state limit is set at £15,000, then:

\[
\text{Years of care} = \frac{\text{Assets}}{\text{Care cost} - \text{Income}} = \frac{\£46,000}{\£15,000 - \£1,600} = 3.42 \text{years} = \text{Band D}
\]

In this variant, state support is therefore set at 0.3 x (£15,000-£1,600) = £4,020, the same as before. These examples are not fixed in concrete and parameters can be varied to suit the consensus.

2.11 In principle, the approach is the same whether a person is cared for at home or in a residential care home. Different tariffs can be set for people with higher or lower needs and for domiciliary as opposed to residential care so that the figure of £25,000 should be regarded merely as an example.

2.12 Our system can be visualised diagrammatically. Figure 1 shows how banding would work according to people of different incomes and assets with the positions of Mrs White and Mr Black indicated. A person on zero income but with assets below £125,000 or a person with no assets but an income of below £25,000 would receive some support under this system.

2.13 The percentage of the 65+ population that would fall into each banded was shown in Table 2. It is important to note that a majority of people would be un-banded at the start of their care journey. If their period in care outlasted their initial care band they would move up to the next band and so on.

2.14 All entitlements would have to pass the appropriate needs assessment which would be universal across the country and strictly applied. The contribution toward the cost of care would then depend on reckonable income (eg whether to disregard any income derived from financial products purchased for care in old age).
Interfacing state support with private finance products

2.15 How this system of state support would work and interface with private finance products is best illustrated by example. Four different types of product are considered: (i) Equity release; (ii) immediate needs annuity; (iii) pre-funded insurance; (iv) disability-linked annuity; and (v) a long term care bond.

2.16 In order to bridge the gap between what the state pays and the cost of care, Mrs White decides to meet the gap by releasing equity from her share of the family home. The money she receives does not alter her entitlement to state support. Mrs White dies after nine months and the balance of her wealth goes to her estate.

2.17 Mrs White’s sister also faces care. She has notional assets to pay for six years care and therefore receives no state support. She opts to buy an immediate needs annuity and decides to buy one that would last six years rather than her whole life. If she lives for more than six years she will receive maximum state support depending on her remaining assets.

2.18 Mr Black is 65 years old and has no partner or children. He decides to buy a small insurance policy that has an affordable premium but which will pay out £100 a week in the event that he has to go into care. This is sufficient to cover the gap but he knows that if he decides to spend down some of his savings he may need to increase his insurance cover.

2.19 Mr Black’s brother has an occupational pension. It is sufficient to provide a level annuity of £5,000 pa. However, at 65 he opted for a disability-linked annuity that paid £4,000 pa but would increase to £8,000 pa on qualifying for care and increase again to £12,000 pa if he entered residential care.

2.20 This is known as a 1/2/3 disability-linked annuity based on multiples of the base annuity. Under our system, only the base annuity of £4,000 pa would count as income for determining state support. The additional disability-linked pension would go towards care costs.

2.21 Mr Black’s sister spent 10 years looking after her elderly mother and has only the state pension plus other welfare benefits as income. She decides to buy five long term care bonds every week over a 10 year period and continues to buy them even though she now has a job.

2.22 During that period she won a prize of £1,000 which was reinvested in her bond account. She is now 75 and may need to go into care. Mr Black’s sister is banded A and so will receive the maximum amount of support. She will be able to encash her bonds and use the money to meet the gap and spend on other needs.

3. Conclusions

3.1 In a short piece like this we have only been able to communicate the bare bones of our alternative approach. Unlike the Commission we have tried to factor in how private finance could make a much bigger

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113 LTC bonds are a new idea which would work like premium bonds and pay out prizes but could only be encashed after receiving a care assessment.
contribution to funding care. We have done this by reconsidering how the value of state support may be calculated.

— The proposed system is simpler and fairer.
— It does not put an arbitrary cap on how much people have to pay towards their care; but it is graduated so that people are protected and those with the greatest means pay more.
— Without a cap the system does not require a bureaucratic metering system which puts additional burdens on care providers. Nor would it require a notional amount of informal care to be computed.
— The method of calculating support is simpler and so individuals would find it easier to plan ahead, either at the point of retirement or point of need.
— It would be easier to create a financial market in care products to suit everybody’s circumstances. The introduction of low cost products would make it worthwhile for people on limited income with few assets and no pension to save for their care.

BIBLIOGRAPHY


October 2011

Written evidence from the Royal College of Nursing (SC 39)

1.0 INTRODUCTION

1.1 With a membership of more than 410,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

1.2 The RCN welcomes the Health Select Committee’s decision to hold an inquiry into the future of social care and is pleased to have the opportunity to submit written evidence.

2.0 EXECUTIVE SUMMARY

— Nursing plays a distinct role in health and social care. Often the lead in the patient journey, nursing staff understand the holistic needs of patients, their carers and families and are in a unique position to cross health and social care boundaries and coordinate care delivery. Their insight into the daily challenges of working in and with social care services is invaluable in the reform of the system.
— The RCN believes that there are a range of factors, including the current economic climate and an aging population, that compound the need to address the future of social care funding.
— The social care system is currently underfunded and there are inequalities in how care is delivered across the country. This variation of service and lack of funding is having a detrimental impact on the health service.
— The NHS is often burdened by the implications of unmet care needs as a result of the “revolving door” and delayed discharge into a social care setting. Of the 4,000 patients in England experiencing delays in discharge everyday, 60% are found to be the result of social care services failing to meet their responsibilities.
— Personal Budgets (PBs) should be optional. Whilst they are successful in improving the sense of control that some groups of people have over their lives, particularly younger physically disabled people, evaluation has shown that older groups found them to be an “additional burden”.

Written evidence from the Royal College of Nursing (SC 39)
— The failure of the business model of Southern Cross showed that sufficient mechanisms are not currently in place to scrutinise and regulate the financial sustainability of providers in social care. The RCN believes that not all business models are appropriate for the provision of care and calls for a review of the financial regulation of care providers by Government.

3.0 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

3.1 Getting funding right in the social care system is crucial for the future sustainability of both social care and the NHS. The urgent need to address the future funding of social care is compounded by the current economic context, a growing ageing population and due to the fact people are living longer with long term conditions and disabilities.

3.2 The current severe underfunding has led to significant unmet need, which often places greater demand on both health and social care systems. The system at present is also subject to a “postcode lottery”, which often fails to deliver quality, personalised care. The arbitrary division between health and social care creates confusion and impedes the provision of integrated care.

3.3 In its response to the Dilnot Commission’s call for evidence on the funding of care and support, the RCN stated that greater investment is needed. This is not just to meet rising demand, but also to improve existing quality and to enable much-needed investment into the workforce. The social care sector has high staff turnover, immense difficulty in recruiting staff, and suffers from skills shortages and a lack of standardised training.

3.4 The RCN’s report, based on a survey of members working in care homes, Care homes under pressure in England found that due to staff shortages and inappropriate skill mixes the complex and multiple needs of the residents are not adequately addressed in residential homes. The workforce needs significant investment, further compounding the urgent need to inject more money into the system.

3.5 Our consultations with RCN members, as well as the previous Government’s consultations with other stakeholders, have shown that the majority of people favour a comprehensive, state-funded social care system. Such a system would enable significantly improved integration with the NHS and help to ensure that patients/service users receive care and support in the most appropriate setting.

3.6 The Dilnot Commission’s proposals include: implementing a care cost cap at between £25,000–£50,000 and increasing the asset threshold for those in residential care beyond from £23,250 to £100,000, whilst offering means-tested support to some service users with lower means. The RCN acknowledges that such plans seek to ensure that the system is fairer. Furthermore, there are some proposals in the report that the RCN fully supports, such as the recommendations that the eligibility criteria should be national, assessments should portable, and that the eligibility and assessment framework should be more objective. The RCN also welcomes the Dilnot Commission’s call for Government to improve the integration of social care with other services, particularly the NHS.

3.7 However, the proposals depend on the financial sector providing services and on the general public taking out care insurance. As successive Governments have found, many people are resistant to buying into private pensions, suggesting that providing for old age does not appear to be a priority. If this is proven to be the case with care insurance, there would still be high levels of unmet social care need, with the same costly implications for health care.

3.8 The Dilnot Commission also recommended that all those eligible for free care would only have substantial and critical care needs met, and not low or moderate needs as can now be the case. This move could affect many people, who may consequently choose to go without care. The RCN noted at the outset that the Dilnot Commission’s terms of reference did not include improving quality of care. This was a missed opportunity, which could be at the detriment of the care received by future generations of service users.

3.9 When the Secretary of State for Health, Rt Hon Andrew Lansley MP, addressed Parliament following the Dilnot Commission’s report, he argued that social care reform would have to meet a number of tests, including: “the level of consensus that additional resources should be targeted on a capped costing for social care, and increasing the asset threshold for those in residential care beyond from £23,250 to £100,000, whilst offering means-tested support to some service users with lower means. The RCN acknowledges that such plans seek to ensure that the system is fairer. Furthermore, there are some proposals in the report that the RCN fully supports, such as the recommendations that the eligibility criteria should be national, assessments should portable, and that the eligibility and assessment framework should be more objective. The RCN also welcomes the Dilnot Commission’s call for Government to improve the integration of social care with other services, particularly the NHS.

3.10 We hope that after a significant delay in any movement on the issue of funding that there will now be swift action from the Government. We would like to see the political parties work together to closely examine
the recommendations of the Dilnot Commission and acknowledge that more money, including from the State, will be necessary to address the failings of the current system. The RCN urges the Government to take action to deliver a funding system that can provide quality, personalised and integrated care for decades to come.

4.0 The scale and implications of existing variation in access to and charges for social care in England

4.1 The impact of existing variation has been well discussed by a range of stakeholders in response to previous consultations, including the RCN. Below is a summary of the RCN’s key concerns on this issue:

— The current system is not fair. RCN members regard fairness—in terms of equitable access across the country—as being of central importance to a reformed social care system. In the RCN 2011 social care survey, 98% of respondents felt that equal access to social care was important.

— Variation in eligibility means that in many places the current “safety net” is not sufficient, with some councils providing for moderate care needs, and others only critical care needs. For example, local authorities in Calderdale, Darlington and Sunderland provide home care for all who need it, whilst overall 70% of authorities now restrict home care to those assessed as having “substantial” needs. Furthermore, cuts to councils’ budgets and the fact that social care budgets are not ring-fenced, has led to a further tightening of eligibility criteria.

— The level of unmet social care needs resulting from variation is of major concern (and is set to rise under current funding arrangements in light of changing demographics). There are also people on the cusp of the eligibility criteria, who may have very low means and very substantial needs who will not be able to afford care. The RCN is aware of a number of examples of people who refuse care packages as they cannot afford to pay and, therefore, go without care or support.

— The NHS is often burdened by the implications of unmet care needs as a result of the “revolving door” and delayed discharge into a social care setting. Of the 4,000 patients in England experiencing delays in discharge everyday, 60% are found to be the result of social care services failing to meet their responsibilities. Social care services are either not assessing the patient for receipt of community care or are unable to provide the care the patients needs to leave the acute setting. It is difficult to quantify the current level of unmet care need but delayed discharge figures could be a way of quantifying unmet social care needs.

— Prevention should be an important element of the social care system, yet variation in eligibility means this is presently not the case. Providing for those with the lowest means and highest needs only, leaves many people with low and moderate care needs and the lowest means without care. A system that does not cater for low and moderate needs, or strive to prevent care needs from escalating, ultimately costs the State more money. Crucially, it also fails to empower people to live independently for longer. A powerful example of where variation within the social care system is currently failing to prevent needs escalation can be seen in the case of the mother in Bristol who asked for her disabled daughter to be taken into care.

5.0 The practical and policy implications of the Government’s commitment to promote personalisation of social care, including personal budgets and direct payments

5.1 The RCN has always maintained that personal budgets (PBs) should be optional. The evaluation of PBs in social care showed they were successful in improving the sense of control that some groups of people who require social care support have over their lives, particularly younger physically disabled people. On the other hand, older groups found them to be an “additional burden”, whilst differences between control groups and budget holders around outcomes were not significant. In a recent National Audit Office report on PBs, around two-thirds of budget holders reported a positive impact on aspects of their well-being, but 3–8% reported being worse-off. 31% of budget holders found it difficult to cope with being an employer, with some instances of employment tribunals being made against budget holders.

5.2 The RCN is concerned about the Government’s national target of 100% take-up by 2013. It simply will not be appropriate for all people to have personal budgets. There are issues around safeguarding; a patient’s cognitive ability and the skills and degree of support needed to make appropriate decisions; and their ability to become an employer and manage the processes involved. The RCN believes that service users must have the choice whether or not to have a PB.

5.3 Furthermore, the policy of mandatory PBs goes against the Government’s explicit aims of the policy, which are personalising care and improving choice. Existing services will need to be run alongside this initiative to maximise choice and personalisation. With this in mind, the Government has to consider the cost of and critical mass required to maintain existing services for those who choose them, in addition to those services purchased by budget-holders.
5.4 The RCN is concerned that the Government views PBs, and Personal Health Budgets (PHBs), as a means to save money. Significant, not diminished resources will be required to make both PBs and PHBs successful for the following reasons:

- demand for care and support is increasing, as people live longer and the baby boom population approaches retirement;
- since PBs must be optional and to realise its goal of personalising care and improving choice, the Government will have to deliver “traditional” services alongside this initiative, and to therefore consider the cost of and critical mass required to maintain them;
- budget-holders continue to require considerable support in the assessment and review of their care needs;
- budget-holders require a range of different support to help them manage their PB and make appropriate choices, including both staff and suitable information resources and diverse formats. In some cases, extensive support is required, which has significant cost implications. Without this support, there will be legitimate concerns that PBs actually increase inequalities, if the lack of support available prevents some from having a PB;
- local authorities currently benefit from economies of scale when commissioning care and support providers for their population. These will be lost if delivering PBs means that budget-holders choose from a much more diverse and plural market. In the personal budget evaluation this was described as “potentially a major tension between volume discounts and delivering individualised services”; and
- owing to the current financial context, some local authorities are already cutting personal budgets. The RCN is concerned about how this will impact on a service user’s condition, limiting the prevention side of the service. It is also likely to impact on the levels of stress that budget holders or their carers have, as they try to manage their conditions with less money.

5.5 The RCN is not convinced that appropriate safeguarding mechanisms are in place to protect both budget holders and the workforce involved in delivering the policy. Criminal Record Bureau checks are seen as a way to help safeguard budget holders. However, the new system will be voluntary for personal care assistants and the RCN does not believe that this will offer adequate protection for risk, in light of the vulnerability of the people they will be working with.

5.6 The RCN has consistently called for mandatory regulation of health care assistants and recently endorsed the Nursing and Midwifery Council’s recommendation for a system of mandatory, not voluntary, regulation of health care assistants. The RCN would like to see the Government looking at how best to safeguard service users in social care in light of issues such as the potential abuse and financial exploitation of the budget-holder by their family, carers or employees.

5.7 There are also safeguarding issues to consider for the employee to ensure that they are not abused or exploited by the budget holder. Budget holders and new providers should have to uphold, and where necessary be supported to do so, the best practice in employment and Human Resources management. These safeguarding issues include pay, terms and conditions. There is an increasing flow of cases being taken to tribunal concerning the treatment of employees by budget-holders. Such situations can be detrimental to the health and wellbeing of both parties concerned, and it is important that mechanisms are in place so that such situations can be avoided.

5.8 There are issues around the sustainability of new providers entering the market. The National Audit Office’s report on personal budgets in social care discussed how disruptive and costly provider failures can be, where alternative providers may need to be found which are lower in quality, higher in cost, or both—at short notice. There are issues around the credentials of new providers and how budget-holders are given information about their services to ensure that they make informed decisions. It will be important that they are not “sold” services through the result of, for instance, a provider’s superior advertising and marketing techniques.

6.0 The barriers faced by recipients of social care when they wish to relocate to another area, particularly with regard to the portability of assessments

6.1 The current social care system is subject to a “postcode lottery” and service users across the country are presented with a myriad of varying eligibility assessments and charges. The RCN believes that this is inherently unfair and ultimately delays access to care, particularly when people move from the boundary of one local authority to another. Such obstacles to the provision of integrated care impact on the health and wellbeing of both those who require care and support, and their carers.
6.2 People who require care and support need a system that is as simple and straightforward as possible. They need to access care and support promptly but instead often have to first understand the localised system of care, including forms, procedures and processes. Even after doing so, they can find that they are no longer eligible for free care within the new local authority area. Not only does this create unnecessary stress but it can influence the life decisions that people who require care and support, and their carers, make (ie they may choose to not move area as a result). A portable assessment is therefore crucial in addition to the application of a national framework which sets a standard of free care and charges that everyone across the country can expect.

7.0 Economic regulation of the social care system including a proportionate failure regime that can mitigate against the failure of social care providers

7.1 The failure of the business model of Southern Cross showed that sufficient mechanisms are not currently in place to scrutinise and regulate the financial sustainability of providers in social care. Care providers deliver vital services for many frail and vulnerable people, including older people. With evidence showing that moving frail and elderly residents from one home to another can be the cause of increased stress-related behaviour, morbidity and even mortality, the stakes of Southern Cross’ failure were high.

7.2 The RCN believes that not all business models are appropriate for the provision of care and calls for a review of the financial regulation of care providers by Government. The review could include looking at those who commission care and ways to support them to proactively use contracts to check financial sustainability and better understand the importance of developing and monitoring robust care contracts. It is crucial that this review is carried out urgently in light of the Government’s proposals to increase plurality in the market.

7.3 The Government must seek to put mechanisms in place to try to prevent failure where possible and to protect patients where it is not. Currently, no body oversees the financial structure of social care providers. Under current legislation, there is a duty on local authorities to provide care to eligible service users and this includes when private providers fail. Such a mechanism at least guarantees some continuation of care, but the issues around moving frail residents remain. The RCN would like to see a fairer distribution of responsibility of this duty between private and public bodies.

7.4 The RCN acknowledges that social care has operated in a plural market for many years, and increasingly local authorities have outsourced social care services. Two-thirds of the social care workforce currently work in the private and voluntary sectors. However, the quality of care provided in this market raises questions as to whether plurality and competition are sufficient levers to be able to improve quality in social care.

October 2011

Written evidence from Consumer Focus (SC 40)

Consumer Focus is the consumer champion for England, Wales and Scotland and for postal consumers in Northern Ireland.

We operate across the whole economy, persuading businesses and public services to put consumers at the heart of what they do. Consumer Focus gives a strong voice to consumers on the issues that matter to them and works to secure a fair deal on their behalf.

We work with consumers and a range of organisations to tackle the problems consumers face and to achieve creative solutions that make a difference to people’s lives.

Submission

We welcome the Government’s broad agenda for reform in social care and the outcomes it is trying to achieve. The Dilnot Commission and Law Commission recommendations go a long way to introducing greater consistency and simplicity into the legal, regulatory and policy frameworks. They also suggest a framework for giving service users more clarity on which services they may be eligible or entitled to, which we also welcome.

The inquiry wishes to consider a number of complex and challenging issues, including the practical and policy implications of:

— Government’s plans for funding social care;
— the recommendations made by the Dilnot Commission and the Law Commission;
— the commitment to promote personalisation of social care, including personal budgets and direct payments;
— the commitment to promote integration between health and social care services;
— portability, local variations in access to and charges for social care in England; and
— economic regulation of the social care system.

128 http://www.prospects.ac.uk/industries_social_care_overview.htm
As the Committee recognises, the challenge is in designing and implementing policies that deliver the intended outcomes.

Consumer Focus strongly believes that this requires embedding the consumer interest throughout the planning and decision-making processes as well as in the inspection and regulatory arrangements. This will help to achieve more effective and efficient provision and regulation of social care, focused on consumer outcomes.

Getting the formal processes right is only part of the story. Those who are at the “sharp end” know from experience what makes a process effective and what needs to be improved. Decisions that take full account of consumer interests are also more likely to deliver outcomes that are seen to be fair.

Our submission focuses on this consumer dimension which is integral to the practical and policy implications of the Government’s plans for funding social care, and which Government will need to consider as it prepares the Social Care White Paper.

**Consumer Interest is Essential**

Consumer Focus and its predecessor body the National Consumer Council have for many years advocated the need to design procedures and services around consumers’ requirements, and to deliver improvements by engaging consumers in the actual design and process of change.\(^{130}\) We would emphasise the importance of engaging effectively and systematically with consumers in order to achieve the goals set out in the Dilnot report.

Our vision is for care services that are designed and run with, not just for, users, who are able to hold providers to account and inform decisions about priorities.\(^{131}\)

Our experience suggests that getting the right legal and policy frameworks in place is only one part of a successful strategy to ensure that consumers get a good deal and decision-makers make the right choices. Key elements of the strategy include:

**Information and Transparency**

The clarification and simplification proposed in the Dilnot report are welcome but consumers will still need to make difficult and complex choices, often on the basis of imperfect information. With increased choice has come increased complexity, with consumers struggling to cope with information asymmetries, as we have seen in utility markets.

Consumers will need access to good quality information about care, with appropriate levels of assistance and protection to make sure they are able to identify the best option for their needs. Defining the appropriate access mechanisms, as well as the criteria for the quality and scope of information to ensure diverse needs are met can only be achieved by talking to consumers.

The social care sector could benefit from offering a greater opportunity for peer to peer support and information sharing so that individuals can share their experiences and insight about care, decision-making and managing their circumstances. This would simultaneously help to improve transparency about the availability of services, their quality and how to obtain redress. Feedback about providers can, in turn, help to improve providers’ performance.

**Empowerment and Engagement\(^{132}\)**

The Government has rightly recognised that empowering people doesn’t happen on its own or simply by providing increasing amounts of information or choice. More active intervention is often needed to get things moving.

It is essential that the widest range of consumers is aware of the changes ahead and the reasons for them. Effective consultation and engagement on the issues that affect them lies at the heart of consumer empowerment.

**Representation, Accountability and Redress**

Empowering individuals and groups of consumers is important, and individuals do need to be aware of their rights and have a direct line to redress when things go wrong.

However, given the complexity of the market and the potential consumer detriment arising from the nature of that market, the social care sector also needs an independent body able to intervene quickly and effectively when quality standards are not met.

Effective scrutiny of providers and regulators cannot be carried out by individual consumers alone. It requires the independent external expertise of a body that represents and advocates the consumer interest.

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\(^{131}\) Ibid

\(^{132}\) See the annex for a list of the features for effective consumer input.
Representing consumer interests in these complex markets requires discrete skills and expertise, including high level consumer policy and research, an understanding of behavioural economics, an ability to understand complex technical issues, how markets work and regulatory trade-offs, and consumer information and engagement expertise.

A representative voice needs to be independent of the regulator. External challenge can improve the quality of regulation by testing the robustness of evidence and analysis that underpins decisions, providing different thinking or solutions, and raising new issues. An effective voice for consumers helps build trust in regulators, boosts legitimacy, and can make a major contribution to the quality of decision-making.

This independent perspective cannot be provided from within the regulator, and needs to be free to work solely on the interests of consumers.\textsuperscript{133} HealthWatch England will need to meet these criteria\textsuperscript{134} if it is to become an effective representative body and play a full part in the overall accountability framework for regulators.

\textit{October 2011}

**Annex**

**FEATURES OF EFFECTIVE CONSUMER INPUT\textsuperscript{135}**

Empowering individuals and groups of consumers will be ever more important in the years to come, but this will not be enough to ensure that consumers are fully involved in major decisions. There also needs to be effective consumer engagement by regulators (for example through qualitative and deliberative research); formal representation of consumers and their representatives in regulatory processes such as price control reviews; and policy work that is independent of regulators in terms of both the choice of topic and the analysis, backed by powers to gather information from regulated providers.

Expert consumer policy work typically encompasses work on market structures, barriers to entry, price controls and other regulatory tools, product design, charging structures, the relationship between input costs and retail prices, sales and marketing practices, billing, sustainability, treatment of disadvantaged consumers, withdrawal of service and debt recovery practices, customer service and redress, consumer information and empowerment, and consumer education. Many of these issues run across sectors, with benefits to be gleaned from a generic approach in many cases.

Effective consumer policy and representation requires a number of capabilities:

\begin{itemize}
  \item Deep knowledge of the market.
  \item Access to high quality research, market intelligence and other forms of evidence, providing insight into the consumer experience of markets.
  \item Understanding that consumer experiences vary as a result of circumstances and needs.
  \item The ability to identify current, emerging and likely future sources of detriment.
  \item The ability to respond flexibly and rapidly to any new problems that arise.
  \item The intellectual framework to analyse evidence and produce reasoned perspectives, for example balancing short- and long-term consumer interests.
  \item Understanding of technical issues relating to products and services and how social, economic and technological changes are affecting markets.
  \item The ability to learn from experience in different sectors.
  \item An understanding of business and consumer behaviour and of the regulatory toolkit.
  \item The ability to put views persuasively, build effective relationships, challenge received wisdom and achieve influence.
  \item Working at local, regional, national, EU and international levels as appropriate.
\end{itemize}

It also requires independence from regulators and certain statutory powers, for example to be a formal consultee with respect to certain regulatory processes, to request information from regulated providers; to make formal representations to the regulator and, where appropriate, to have powers of appeal to regulated providers that are symmetrical with those of the industry.


\textsuperscript{134} See annex for more detail.

\textsuperscript{135} From \textit{Regulated industries and consumers}, Consumer Focus, March 2011.
Written evidence from the Care and Support Alliance (SC 41)

1. ABOUT THE CARE AND SUPPORT ALLIANCE

1.1 The Care and Support Alliance is a consortium of over 50 organisations that represent and support older and disabled people, those with long-term conditions and their families. Formed in July 2009, the Alliance has been at the forefront of raising political awareness of the chronic underfunding of social care and continues to work to achieve sustainable reform of the care and support system and how it is funded.

1.2 The evidence presented is based on research commissioned by the Care and Support Alliance alongside that of individual organisations.

1.3 A number of organisations supporting the submission have in addition submitted individual responses.

2. SUMMARY

2.1 The Care and Support Alliance has welcomed the recommendations from the Dilnot Commission on the Funding of Care and Support and the recommendations of the Law Commission on Adult Social Care.

2.2 Evidence from across the Alliance indicates that funding for social care is failing to keep pace with the rising demand. In the last year alone, the number of new contracts to councils responsible for providing social care rose by 4% to 2.12 million.136

2.3 With an ageing population and people living longer with illness and disability, we strongly believe that future reform needs to meet the current historical shortfall as well as being socially and financially sustainable in the long term.

2.4 The Alliance fully supports the Government’s proposals to bring forward a White Paper in April 2012, but this must include a package of fundamental reforms that deliver clear proposals and a way forward for funding social care in the short and longer term.

3. OUR PRINCIPLES

3.1 We are committed to creating a social care system that:

— Sees people of all ages as equal citizens, unique individuals, valued and diverse members of society. This means giving people equal respect and supporting equal life chances, regardless of age, medical condition, disability and caring activity.

— Sees social care and support as defined by people’s lives, not the other way round. This means the provision of social care and support should not be driven by the capacity of services but instead led by the demands of people.

— Promotes human rights, empowerment and participation in family and community life. This means recognising the value of empowering people to establish and/or maintain dignity and independence.

— Aims at fair outcomes for all alongside efficiency and effectiveness in services. This means fairness between different people who use services, fairness between those who are or who are not eligible for services, and fairness between those who need support and the rest of society as a whole.

— Recognises, respects and values the circumstances and values the role and contribution of family and friends who provide care.

— Is funded in a way that is simple and fair, across generations and for generations to come. This means building consensus around what is fair and equitable and being open, clear and transparent about how, when and what will be funded.

— Has the delivery of high quality care and support at its heart and puts people in control of their lives.

— Is sustainable socially and financially. This means there are reasonable and negotiated resources and expectations (now and in the future) from and on all sections of society and the system is not based on exploiting workers, carers or people who use services.

— Promotes integrated and collaborative working across all agencies to ensure people enjoy choice and control over a good quality of life through getting the support they need in the way they want it. This includes addressing the artificial barriers between health and social care and between children’s and adults services.

— Challenges and changes attitudes to difference, illness, injury, disability and ageing inside and outside social care.

4. THE CURRENT FUNDING SITUATION: SHRINKING SERVICES AND GROWING DEMAND

4.1 The LGA (the Local Government Association) and ADASS (the Association of Directors of Adult Social Services) calculated that the current funding shortfall is now nearly £4 billion.\(^{137}\)

4.2 In 2005, half of councils provided support to people assessed as having “moderate” needs, but in 2011 the figure has fallen to 18%. As a result, the number of people receiving local authority funded care at home has reduced from 489,000 in 2004 to 299,000 in 2009.\(^{138}\)

4.3 A 2011 Learning Disability Coalition survey of councils showed 57% of councils were increasing charges or raising eligibility criteria, or consulting on doing so. A survey of people with learning disabilities and their families showed that one in five had been told their hours of care would be reduced.\(^{139}\)

4.4 In 2008, an estimated 4.1 million contact hours were provided to around 328,600 households—compared with 2007 this represents an increase in the number of contact hours of 5% and a fall in the number of households receiving home care of 2%. This suggests that Councillors are providing more intensive services for a smaller number of service users.\(^{140}\)

4.5 Age UK report that 800,000 older people who currently need care, receive no formal support from either the state or private sector agencies.\(^{141}\)

4.6 Tipping point for care: by 2017 the number of older people requiring care will exceed the number of family members able to provide it.\(^{142}\)

4.7 In addition, the dependency ratio—the number of people working versus those in retirement—will increase significantly from its current level of 4 to 1, to 3 to 1 by 2029.\(^{143}\)

5. GOVERNMENT PROPOSALS

5.1 In the Comprehensive Spending Review, the Government set aside an additional £2 billion for social care funding. £1 billion was to be given to social care by 2014, with a further £1 billion transferred from NHS budgets.\(^{144}\) Despite this, the funding was not ring-fenced and local authorities also received a reduction in their total revenue from Government of 27% over the next four years.\(^{145}\) The impact of this was recognised in the *Dilnot Report* which states; “the impact of the wider local government settlement appears to have meant that the additional resources have not found their way to social care budgets in some areas”.\(^{146}\)

5.2 As a result, an ADASS survey showed overall budget reductions of £1 billion for 2011–12, at a time where increased demand should require £425 million worth of new services.\(^{147}\) ADASS has stated that services will face cuts of the same level or greater next year.\(^{148}\)

5.3 Measures set out in the Comprehensive Spending Review are a short-term response: they do not deal with either long term demographic change, nor tightening budgets across local government spending.

5.4 Were a long-term funding solution for social care not provided, there are likely to be significant knock-on, avoidable costs across Government, particularly on Department of Work and Pensions and Department of Health budgets.

5.5 The Alliance is also concerned about the wider impact on families of cuts to social care. There are 6.4 million carers in the UK who, without the right support, face financial hardship, isolation and ill health.\(^{149}\) As part of this, one million people have given up work or reduced working hours to care for ill or disabled friends or relatives.\(^{150}\) Over 40% of carers who gave up work did so due to a lack of sufficiently reliable or flexible services.\(^{151}\) Of those who do continue to work, the added stress of juggling serious care needs or caring responsibilities with employment is likely to place added costs upon employers with periods of absence from work.

\(^{137}\) Shaping the Future of Care Together (2009).

\(^{138}\) Care in Crisis (2011) Age UK.


\(^{141}\) Care in Crisis (2011). Age UK.

\(^{142}\) Tipping Point for Care (2010). Carers UK.

\(^{143}\) Tipping Point for Care (2010). Carers UK.


\(^{146}\) Fairer Care Funding, (2011). Commission on Funding of Care and Support.

\(^{147}\) ADASS received responses from 98% of English councils.


\(^{150}\) One million give up work to care (2009). Carers UK, DWP, Ipsos MORI.

6. THE DILNOT REPORT

6.1 The Dilnot Report provides a strong foundation for delivering a clearer, fairer system, and the best offer yet that risk can be shared. The proposals in the report would protect families from catastrophic care costs, provide greater opportunities for care planning to start earlier and be better integrated into income protection, planning for disability or chronic illness, pensions or insurance.

6.2 We warmly welcome the report’s emphasis on delivering a system which recognises the needs and costs of younger disabled adults as well as older people.

6.3 In particular, the Alliance would welcome the introduction of a national system of eligibility and assessment. Through increasing the portability of assessments and implementing standardised charges for care at home across local authorities, much of the uncertainty which faces individuals and families would be minimised. It will be crucial for the Government to consult on the setting of a national eligibility threshold.

6.4 However, we believe that there must also be a clear focus on lower level need and preventative services if a sustainable funding solution is to be reached, and would highlight Dilnot Report’s recommendation that there is a clear need to “devote greater resources to the adult social care system”.152 With the current tightening of eligibility criteria for access to social services support, this issue is likely to take on greater significance.

6.5 In order to increase awareness of the necessity of planning for care, we strongly agree with the need for a new awareness, advice, information and advocacy campaign around care planning, to enable options to be understood and choices to be made.

7. THE LAW COMMISSION REPORT

7.1 The Care & Support Alliance welcomes the Law Commission’s Report on the Reform of Adult Social Care, broadly supports all the recommendations and would like to see them implemented as soon as possible. We believe that by simplifying and clarifying the law the system will work better both for users of services and professionals. We believe that the recommendations of both commissions related to assessments and portability fit very well with each other.

Signatories:
Action on Hearing Loss
British Red Cross
Carers UK
Crossroads Care
Huntington’s Disease Association
Independent Age
Learning Disability Coalition
Macmillan Cancer Support
Marie Curie Cancer Care
Mencap
Motor Neurone Disease Association
MS Society
National Autistic Society
National Care Forum
National Centre for Independent Living
National Voices
Parkinsons UK
Princess Royal Trust for Carers
Radar
RNIB
Sense
Shaping Our Lives
Shared Lives Plus
VoiceAbility

October 2011

152 Fairer Care Funding (2011). The Commission on Funding of Care and Support.
Written evidence from the Learning Disability Coalition (SC 42)

The Learning Disability Coalition is pleased to be able to contribute to the Health Select Committee’s Inquiry into social care. The Learning Disability Coalition has 15 member organisations and over 160 supporter organisations, and since its formation in 2007, has argued the case for better and more sustainable funding for social care support for adults with a learning disability. We support the points made in the submissions of our member organisations who have also made individual responses to this consultation; Sense, Turning Point, Mencap and United Response. The Learning Disability Coalition is a member of the Care and Support Alliance.

SUMMARY

— The current social care system is underfunded and unable to meet current need—the situation will only worsen as the number of people who need social care increase.
— The extra money allocated in the Comprehensive Spending Review is welcome, but there is little evidence to show that it has reached the frontline of social care or how it will be allocated in the future.
— We welcome the Dilnot Commission’s proposal for free care and support for people who reach adulthood with a care and support need, but are concerned that this may exclude a number of people who are born with a disability but who develop a care and support need later in life.
— We welcome the introduction of national eligibility criteria; but this must not be used as a means to exclude people with low and moderate needs from the care and support system.
— The Learning Disability Coalition is cautious about welcoming the roll out of personal budgets and direct payments as there is emerging evidence to show that local authorities are using personal budgets as a means to cut care packages.

RESPONSE

1. The practical and policy implications of the Government’s plans for funding social care and the recommendations made by the Dilnot Commission and Law Commission

1.1 The Learning Disability Coalition is supportive of the reforms proposed by the Dilnot Commission, but believes that these will be ineffective without additional funding. The Government allocated an additional £7.2 billion to social care in the period to 2014–15, but much of this will be absorbed by increasing demographic demand. The number of people with a learning disability is expected to rise by 30% over the next 20 years. It is to be celebrated that people are living longer lives, but more care and support will be needed over longer periods of time so that people can live the lives they want to lead.

1.2 The Learning Disability Coalition is concerned that the Government will require local authorities to implement the recommendations of the Dilnot Commission but insist that they do this within the current Comprehensive Spending Review settlement. This will lead to even more cost pressure in an area that is already one of the major places where cuts are being experienced and a care system which continues to fail thousands of people.

1.3 The Learning Disability Coalition is concerned that the focus of the concrete recommendations in Dilnot Commission report are predominantly concerned with older people and protecting housing assets. We are calling on the Government to ensure that working age people with learning disabilities are not forgotten, as this group is unlikely to be able to build up assets. Whilst many people with a learning disability will be entitled to free care under the Dilnot recommendations, there is a significant group of people with a learning disability, living with their families who may not present a care and support need until after they are forty years old—perhaps as a result of a crisis when their parents become ill or die. It is unclear whether this group, who are disabled from birth, will be eligible for free care.

1.4 The Learning Disability Coalition believes that any changes to the social care system should be accompanied by a duty on local authorities to improve their data collection and publication. Currently very little is known about the numbers of people with learning disabilities, their levels of need and where they are. In order to commission high quality and relevant services, local authorities need the most up-to-date data on who in their local area needs care and support.

2. The scale and implications of existing variation in access to and charges for social care in England

2.1 The Learning Disability Coalition welcomes an end to the postcode lottery through the introduction of national eligibility criteria. However we are concerned that the Dilnot Commission has recommended this should be set at “substantial”:

153 Association for Real Change (ARC); BILD (British Institute of Learning Disabilities); The Down’s Syndrome Association; Foundation for People with Learning Disabilities; the Hesley Group; Mencap; National Autistic Society; People First; Real Life Options; Sense; The National Forum for People with Learning Difficulties; National Family Carer Network; Turning Point; United Response and Voyage.

154 http://kingsfund.koha.ptfs.eu/cgi-bin/koha/opac-detail.pl?biblionumber=100638

2.2 Currently 82% of local authorities provide services to people with critical or substantial needs—up from 62% in 2007.\textsuperscript{156} This means that people with moderate and low needs will be further excluded from receiving care and support. Low level support can be essential to enable people to live safely and can prevent people requiring more costly services later on.

2.3 The Learning Disability Coalition has an additional concern about the Government’s intention to target disability benefits at those with the highest needs. This is at odds with the Dilnot Commission’s recommendations that disability benefits should support people with lower needs. It raises serious concerns that people with mild or moderate care needs, who may have high disability-related expenditure, could be excluded from social care support and support from disability benefits.

3. The practical and policy implications of the Government’s commitment to promote personalisation of social care, including personal budgets and direct payments

3.1 The Learning Disability Coalition is cautious in welcoming the Government’s commitment to rolling out personal budgets and direct payments to everyone who uses social care by 2013. The recent report, Tailor Made by Demos describes some of the challenges of delivering personalisation with personal budgets and direct payments and asserted that “personalisation can be achieved without personal budgets. But we should be far more concerned about the challenges that personalisation—in its widest sense—faces from budgetary constraints and significant reform to local health and care services”.\textsuperscript{157}

3.2 Whilst personal budgets and direct payments may provide people with learning disabilities the freedom to choose their own services, this is not the reality for most people with a learning disability. Many people are being told by their local authority how much they are allowed to spend per hour on care which severely limits what they are able to do.

3.3 Furthermore, our member organisations have gathered evidence which suggests that local authorities are using personal budgets as a means of cutting funding to people who need care and support.

3.4 If personal budgets and direct payments are to be successful for people with learning disabilities, local authorities need to provide high quality information, advice and advocacy services. There is some concern as to whether local authorities will be able to provide this under the current financial settlement. A survey of local authorities carried out by the Learning Disability Coalition in early 2011 showed that 11% of local authorities were already cutting advocacy services and this number is expected to rise.\textsuperscript{158}

October 2011

Written evidence from Sense (SC 43)

Summary

— Deafblind people need a care system that will recognise their need for support with communication and mobility, rather than personal care. Social contact and involvement in community life should be on a par with personal care needs.

— Deafblind people need a system that will fully fund the services they need, even where this is more expensive than average.

— Sense supports the Dilnot Commission proposals for a cap on care costs, but does not believe that this alone will solve the funding crisis in the current system. Adequate funding for the current system is needed before reform can be effective.

— The care system plays a significant role in the economy, and funding the care system should be seen as an investment in the economy not a burden.

— Charging against income should be tapered, as recommended by the Dilnot Commission.

— Personalisation requires increased clarity about the definition of a personal budget.

— Portability requires not just portable assessments, but the ability to have an assessment and care plan before a person moves from one area to another.

1. About Sense

1.1 Sense is the leading national charity that supports and campaigns for children and adults who are deafblind. We provide expert advice and information as well as specialist services to deafblind people, their families, carers and the professionals who work with them. We also support people who have sensory impairments with additional disabilities.

\textsuperscript{156}http://www.adass.org.uk/images/stories/Policy Networks/Resources/Key Documents/ADASS Budget Survey Summary May 2011 10.5.11.doc

\textsuperscript{157}http://www.demos.co.uk/files/Tailor_made_-_web.pdf?1318945824

\textsuperscript{158}http://www.learningdisabilitycoalition.org.uk/download/Social%20Care%20-%20The%20Continuing%20Crisis.pdf
2. **About Deafblindness**

2.1 Deafblindness is a combination of both sight and hearing difficulties. Most of what we learn about the world comes through our ears and eyes, so deafblind people face major problems with communication, access to information and mobility. People can be born deafblind, or become deafblind through illness, accident or in older age.

2.2 The commonest cause of deafblindness is older age. Any system which is put in place to support an ageing population must take account of the fact that a significant number of those it aims to support are deafblind. Deafblind older people cannot easily use mainstream services unless those services adapt to the needs of a deafblind person.

2.3 Those who are born deafblind often have very high levels of need throughout their lifetime. A person born with a high level of hearing and sight loss will struggle to learn and may never develop formal language.

2.4 Deafblind people therefore experience a range of different needs and circumstances. These examples may seem diverse, but they also have some factors in common.

<table>
<thead>
<tr>
<th>Type of support needed</th>
<th>Deafblind people do not predominantly need support with personal care. The majority of their support needs relate to mobility, communication and access to information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complexity</td>
<td>The experience of dual sensory loss is difficult for a hearing sighted person to understand. Even professionals with a single sensory specialism find it hard to understand the needs of those with both hearing and sight loss. This is particularly true of those born deafblind.</td>
</tr>
<tr>
<td>Cost of support</td>
<td>Deafblind people often require support from people with specific skills, such as specialist communication skills. This can mean that the hourly cost of this support is higher than average. Those born deafblind often require a high level of ongoing intensive support which can make their total care package comparatively large.</td>
</tr>
</tbody>
</table>

3. **The Dilnot Commission Recommendations**

3.1 It is widely recognised that the numbers of people requiring care and support will increase over the coming years because of demographic changes. This is due to the ageing population and to the higher numbers of very disabled children who survive to adulthood, often with very high support needs. The cost of this additional support is unavoidable. If the current funding system remains the same, most older people will pay for the care and support they need themselves, while a smaller number, including the majority of working age adults, will depend on the means tested state funded system. This has a number of negative impacts for deafblind people:

| People who have to pay for support but do not feel they can afford it will refuse services. Sense knows of many people who have been assessed as needing a communicator guide service but who refuse that service because of the level of charges. This has a major impact on their physical and mental health. |
| If the means tested system is underfunded, as it currently is, the threshold to access means tested services will continue to be too tight. This means that people will not receive the services that they need, with a knock on impact on their health and on informal carers. |

3.2 One problem with the means tested system is that people feel it is unfair that those who have saved all their lives lose those savings if they develop high care costs. The cap proposed by the Dilnot Commission is a solution to this aspect of the problem with social care, and as such we welcome it. However, the cap alone will not bring new money into the system, nor will it address the points raised above. Other proposals by the Dilnot Commission have received less coverage, but are equally important in addressing these issues and we look at each of these in turn.

**Charging against income**

3.2.1 The Dilnot report recognised that as well as charging against assets, there is also an issue of charging against unearned income, including pension income. Currently the law allows a person who has income above Income Support plus 25% to be charged for their services. 100% of any additional income above the threshold can be taken in charges. Not only is Income Support plus 25% very little for a person to be left to live on, it is also seen as unfair that those who have paid into an occupational pension should lose such a significant proportion of this in charges. We believe that the Government should implement the proposal in the Dilnot report to introduce a 65% taper on charges against earnings. We also believe that the threshold for charging against income should be raised at least to the level currently in operation in Wales of Income Support plus 50%. We believe that this would be seen as fairer and would reduce the numbers of people refusing services because of the level of their charges.
Eligibility

3.2.2 The Dilnot report proposed a review of the current Fair Access to Care (FACS) eligibility criteria and that there should be a national eligibility threshold. If the FACS eligibility system is to be reviewed there are some aspects of the system that we would want to see preserved as they are vital for deafblind people.

3.2.3 Maintaining social contact is vital to maintaining good physical and mental health. Although the FACS criteria recognise that involvement is as important as health and safety, the needs of deafblind people for social interaction are often deemed not to meet critical or substantial eligibility criteria. They are simply not seen to be as important as personal care. Too often we hear of deafblind older people who are considered to be “safe” in their favourite chair at home with little other support or intervention. Without support, they become prisoners in their own home, isolated from friends, family and community, with a lifestyle that threatens their physical and mental health.

“From leading an enjoyable, full and active life—I am now down to nothing…now I can only watch TV (close seat) and have to make up my own dialogues. Strange but friends do desert you when you cannot communicate.”

3.2.4 Any eligibility system needs to place social contact and involvement in community life on a par with personal care. The Law Commission proposals explicitly recognise this in their recognition that social care services should address outcomes including the contribution made to society. “It is important that adult social care services should help service users to take part in society, for example through the provision of communicator guides to deafblind people.” In their discussion they make reference to the “Article 8 rights of disabled people to participate in the life of the community and to have access to essential economic and cultural activities.”

The role of disability benefits

3.2.5 One of the important requirements for prevention is rapid provision of low level services when needs first develop. The Dilnot report proposed that this would be a role for disability benefits—Attendance Allowance or Disability Living Allowance equivalents being provided when needs first develop to provide for low level need, with social care services being provided when a person’s needs increase. For this to work, disability benefits would need to have a low threshold for qualification. While the precise thresholds are still to be decided, current government plans are to focus Personal Independence Payment (PIP), the replacement for DLA, on those “with the greatest need” in order to reduce the total cost. These changes to disability benefits will therefore take them in the opposite direction, meaning that those with lower level needs would receive nothing from either system.

The underfunding of the current means tested service

3.2.6 The Dilnot report is very clear that in addition to funding the capping system, the current means tested system needs to be properly funded. “Without extra resources, people are not going to get the care that they need, the quality of support is likely to decline and extra pressure will be placed on other services. The Government should ensure that there is sufficient, and sustainable, funding for local authorities so that local authorities are able to manage the existing pressures as well as the new requirements as a result of our reforms.” Sense believes that other improvements cannot work with an underfunded system.

3.2.7 Social care is usually discussed in relation to the need to reduce the cost, or burden, of care services to the state. Sense believes that this is a short sighted approach for two reasons: firstly the care sector plays a significant role in the economy of the UK and secondly failure to provide social care can have costly implications for other state funded services, most notably the NHS.

3.2.8 Skills for Care estimate that the number of jobs in adult social care in England in 2010 was 1.77 million and the actual number of people doing these jobs was 1.56 million. This means that over 5% of people employed in the UK are employed in social care. Investing in a sector which is relatively low paid could create significant numbers of jobs. Skills for Care estimate that the number of jobs in adult social care is projected to grow between 2010 and 2025, so that there could be between 2.1 million and 3.1 million jobs by 2025. The underfunding of social care also impacts on the ability of disabled people and carers to take up and maintain employment and so contribute to the economy.

3.2.10 If deafblind people do not get the support they need, the impact on their physical and mental health can be profound. For example, research has found that older people with dual sensory loss are more likely to develop certain additional health conditions such as stroke, arthritis, heart disease, hypertension, falls and

159 VICTAR, (2007), Secondary data analysis with a focus on the needs of older people with acquired hearing and sight loss: An analysis of the “Network 1000” and “Cambridge” datasets, 45.
161 Dilnot Commission (2011) Fairer Care Funding paragraph 8.22.
depressive symptoms. By definition, deafblind older people will be more likely to have difficulty with all the activities recommended in order to remain healthy: moderate exercise, mental stimulation, maintaining social contact and healthy eating. Offering deafblind older people the right preventative support could reduce this cost and crucially preserve their wellbeing. Without support, deafblind people are also unable to access other preventative services, such as exercise classes or access to information about healthy living.

4. PERSONALISATION

4.1 Sense supports the aims of personalisation of giving people choice and control. However, the rhetoric about personalisation is at odds with the low level of safety net. If you can receive support only when your needs reach critical band, then choice and control over your life will be extremely limited.

4.2 In addition, in many areas, personalisation has been introduced using mechanistic resource allocation systems (RAS). These often lead to deafblind people’s needs not being recognised, as the questions and the points weighting relate to personal care rather than other aspects of support. A clear example of this bias can be seen in the ADASS Common Resource Allocation Framework. This asks a series of questions and allocates points according to level of need in each area. If the answer to the question related to personal care needs is: “I need frequent support/encouragement with my personal care (eg several times a day)” this will accrue 13 points. Up to a further 10 are available if support is needed with eating and drinking. The answer to the question about needing support to be part of the local community: “I want to be part of my community and regularly need a lot of support to do this (eg daily or several times each day)” merits only six points.

4.3 There is a clear bias here in favour of supporting people with personal care needs above those with other types of support need. There is no question on the Framework about communication, mobility or access to information; indeed communication is addressed in less than half of the RAS questionnaires that Sense has seen.

**Personal budgets**

4.4 If the concept of personal budgets is included in the new statute it is essential that this includes clarity about what is meant by the term personal budget. The Government’s Vision for Adult Social Care states that “People, not service providers or systems, should hold the choice and control about their care.” It also states that the provision of personal budgets to all eligible people is part of that. However, the Vision contains no definition of the term personal budget. We are aware of a range of differing definitions in practice:

— people who have been told that their direct payments have been converted into a personal budget, but without any change other than the name;
— authorities where the term is seen as synonymous with direct payments;
— people who have been told that they should not ask for a personal budget because this will result in their getting less money than they currently have;
— a wide variation in the level of flexibility people are allowed in how they spend their budget.

4.5 It is our understanding that the crucial feature of a personal budget is the additional freedom it gives the individual to choose how they want to be supported, rather than have this decided by the local authority. However, many definitions focus on the provision of “an up front allocation of money” as the defining feature. We believe that it is flexibility in how the money is spent which is key to giving people choice and control.

4.6 Sense believes that the development of personal budgets requires:

— Clarity over what is meant by the term personal budget, to include flexibility of the use of the funds as the key feature;
— A legal requirement that the budget must be sufficient to meet all eligible needs;
— That there must be choice over how the budget is delivered—direct payment or a directly provided service.

5. PORTABILITY

5.1 The main barriers to portability for deafblind people are:

— A person has to move house before they are considered for assessment.
— The delay in carrying out that assessment can be long.
— Once the assessment is carried out there is further delay while a service is put in place.
— Variations in eligibility and charging lead to uncertainty about what services will be received.

5.2 If a person has high support needs this effectively prevents them, or any member of their family living with them, from moving out of the local area. We do not believe that simple portability of assessments will solve the problem. Once a person moves house they may well have very different needs, eg if they move out

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of a family home to live alone, nearer to or further from work, from urban to rural setting or vice versa. So even if a portable assessment were introduced, many people would still need to be re-assessed after a move, with the consequent delays.

5.3 We support the enhanced duty to co-operate proposed by the Law Commission. However, whilst the enhanced duty to co-operate would assist with portability, we do not feel it is sufficient. We would like to see the duty to assess where a person is likely to move house much clearer in the statute. Once it is clear that a person is going to move to an area they should be able to request an assessment. The local authority should then be under a duty to conduct the assessment within a reasonable time, even if the person has not yet moved.

5.4 One issue for those with very complex support needs is that local authorities are reluctant to accept responsibility for funding an expensive package. This exacerbates the delays in assessment and service provision. Sense believes that where a person has a package above a certain cost per year, a central fund should cover the cost above the agreed threshold. This would mean that people with very complex needs could move from one area to another without having a disproportionate effect on a local authority’s budget. We would like to see some consideration of the Independent Living Fund being converted into such a system.

6. Conclusion

6.1 Deafblind people need a social care law which recognises their specific needs. This includes specialist assessments and support at a sufficient level to meet needs, a recognition of the importance of meeting needs other than personal care needs, and adequate funding for the new system. Sense believes that we can afford to bring in such a system, in fact, the potential benefits to disabled people, the NHS and the economy mean that we cannot afford not to.

October 2011

Written evidence from My Care Umbrella (SC 44)

1. Executive Summary

1.1 CEO of My Care Umbrella, Karen Garner welcomes the opportunity to respond to the call for evidence for the Social Care White Paper.

1.2 Garner is well placed to give evidence on how government policy and recommendations affect service users and providers on the ground. She is a qualified social worker, with over 15 years experience as a practitioner and social care entrepreneur. Garner set up and grew two national care companies that she later sold to Care Tech Plc and The Priory Group.

1.3 Engaging the private sector’s experience and involvement in the development of the White Paper’s recommendations will be central to the Government’s success in achieving fair access to support and independence for service care users. Both of Garner’s previous companies (One Step at a Time and Positive Living) have translated government policy (The Leaving Care Act and then Putting People First) into real outcomes of independence and improved quality of life for service users.

1.3 Garner set up My Care Umbrella in 2011 to support the Government’s agenda for personalisation, including rolling out personal budgets and using direct payments to carers to improve respite care. This is born out of a passion to ensure that service users have access to all services to promote the transformation of adult social care.

1.4 My Care Umbrella is set to address the current issues of inaccessibility, confusion, anxiety and lack of support that service users and providers currently using personal care and private budgets to purchase care services and products tell us that they have. By creating a safe and easy to use service user focused marketplace, that brings service users and providers of products, services, support and care together in one place, My Care Umbrella is seeking to support the Government’s ambitions for “reforming the system of social care” by using market forces to drive improvements in the sector.

2. Using Personal Budgets and Direct Payments

2.1 The Law Commission’s recommendation for using direct payments for residential care is the central component of using personalisation to provide more independence, choice and control for service users.

2.2 Engaging the involvement of service users and their carers is key to creating personalised and non-institutionalised standards of care. A high-percentage of people requiring residential and on-going care have the capacity to act for themselves or are well-supported by loved-ones who will act in their best interests on

167 One Step at a Time exists to promote choice and independence for the people who choose to receive its services. http://www.onestepatatime.org.uk/
168 Positive Living Ltd specialises in offering placements that mirror the Government’s White paper, Our Health, Our Care, Our Say. http://www.positivelivingltd.co.uk/home.aspx
their behalf. This understanding is based on Garner’s experience of providing personalised residential care placements to people through her company Positive Living from 2007 to 2010.

2.3 Eradicating institutionalised practices is central to providing more independence, choice and control for service care users. One of the ways this can be done is through direct payments. For example, direct payments would enable thousands of people in residential care to create a more personalised care package for themselves or for their loved ones to act on their behalf to do this. This could include leaving residential, more institutionalised care, to be more individualised care by a supported living provider that is registered by the CQC as a domiciliary care provider.

2.4 Direct payments will increase the need for care planning services, but this is a state provision that care service users should be entitled to. Although it will initially increase, this will be a short term requirement and then massive savings could be made by the Government as there will not be such high levels of finance officers required to pay providers.

2.5 The fear that residential and other provider costs will increase if purchased on an individual, rather than bulk basis by local authorities, is unjustified. Local councils know how much services cost and how much they are paying for them now. Most local authorities, especially in the case of older people’s care, have a ceiling on how much they will pay for an individual and this should stay the same. Local authorities should enforce current cost ceilings by restricting personal care budgets to existing cost structures.

2.6 The social care industry will have no choice but to become more competitive as a result of personalisation. When the general public has more control over services they receive for either themselves or a loved one people will be able to better examine services and demand improvements in provision. This will drive up standards of care.

2.7 Removing local authorities’ grip on offering a set number of care providers to service users will open up the market place to a wider range of services. Typically, local authorities provide just three options and these can be driven by existing relationships and personal preference. Opening up the marketplace to a wider range of providers will drive up quality through competition and a more empowered general public.

2.8 Easily accessible and well balanced information on what service users and their carers should look for when choosing a provider will help to better safeguard individuals. Educating individuals as consumers of social care services and products will be central to the personalisation agenda’s success in improving service users’ independence and quality of life. Online information will be a key to this educational drive. Providers should be used to support this educational drive as improved understanding of the services they offer should improve the numbers of leads and conversions they receive.

3. STANDARDISING ELIGIBILITY CRITERIA

3.1 The current system that enables local authorities to operate to different eligibility criteria, based on local priorities and associated budget restrictions on adult social care, needs to change to enable government to positively engage service users with reform. To do this central government needs to ensure that all local authorities can offer funding based on the same eligibility criteria. Service users should not be penalised simply on the basis of where they live.

October 2011

Written evidence from GMB (SC 45)

EXECUTIVE SUMMARY

— GMB welcomes the opportunity to submit evidence to the Health Committee’s inquiry into social care. GMB is the largest trade union for care-home staff in the independent sector.

— It would be naïve in the extreme to assume that the crisis in Britain’s care homes has now passed. GMB is far from convinced that the landlords and financiers responsible for the carve-up of Southern Cross Healthcare have found a safe berth for all of Southern Cross’s 31,000 elderly and vulnerable residents and 44,000 staff.

— We are deeply concerned about the financial viability of Four Seasons Healthcare, 40%-owned by RBS. It is difficult to see how Four Seasons can pay debts of £780 million due to be repaid next September from assets of £330 million. For the 140 Southern Cross homes due to transfer to Four Seasons by the end of October, we fear it is a case of “from the frying pan into the fire”.

— The Government appears relaxed about the fact that the replacement operators for Southern Cross homes “may decide to close some homes”. Yet closures may have direful consequences for residents, given the known risks of premature death associated with forced moves.

— The Department of Health’s paper, Oversight of the Social Care Market, tentatively tables proposals for greater regulation which are broadly to be welcomed. GMB will be advocating the maximum possible regulatory safeguards.
— GMB calls for a root-and-branch review of social care, to include:
— a public inquiry into the Southern Cross debacle;
— security of tenure for residents;
— an adequate national statutory minimum entitlement to care;
— measures to take all care homes out of private-sector ownership; and
— for as long as care homes remain in the private sector, an end to the lack of financial accountability of care-home operators and their landlords.

In the immediate future, we fear that Four Seasons will require urgent attention and possible intervention by Government to stop it becoming “the son of Southern Cross”.

FOUR SEASONS HEALTHCARE

1. In the wake of the collapse of Southern Cross Healthcare it would be naïve and irresponsible to assume that the crisis in Britain’s care homes is over. We continue to have on our hands a “financially stressed care homes industry”. GMB is far from convinced that the landlords and financiers responsible for the carve-up of Southern Cross have found a safe berth for all of Southern Cross’s 31,000 elderly and vulnerable residents and 44,000 staff. Outside of the former Southern Cross, there are also other care-home and domiciliary-care companies in poor financial health.

2. During the 18 months prior to the collapse of Southern Cross Healthcare, GMB warned time and again that the financial model of the country’s largest care-home operator was unsustainable. Today we are deeply concerned about the financial viability of at least one of the operators which are taking over the running of Southern Cross homes. Our primary concern is for the viability of debt-soaked Four Seasons Healthcare.

3. Four Seasons is set to replace Southern Cross as the UK’s biggest care-home operator. It already operates over 420 care centres and nursing homes accommodating 17,500 people and employing over 21,000 staff. For the 140 Southern Cross care homes due to transfer to Four Seasons by the end of October, we fear it is a case of “from the frying pan into the fire”.

4. The Telegraph described Southern Cross as “a salient example of the dangers of debt-fuelled excess”, but Southern Cross was not alone in its irresponsible financial speculation. Four Seasons is from the same private-equity background. Four Seasons has debt of £780 million which is due to be repaid in September 2012. The debt has already been deferred by creditors from September 2010. It is difficult to see how Four Seasons can pay debts of £780 million from assets of £330 million. The company recently posted a £12.1 million pre-tax loss for 2010 and is effectively controlled by its bankers, chiefly RBS.

5. Four Seasons will presumably use a portion of the (largely public) income it receives from residents and local councils, which ought to be used to provide care, to service the interest on this enormous debt. This is totally unacceptable.

6. There is an overwhelming public and taxpayer interest in Four Seasons. The company is 40%-owned by RBS, following a debt-for-equity deal in 2009. This will make it difficult for the Government to repeat its approach to the Southern Cross crisis, when it refused to intervene in what it dismissively described as merely “a commercial-sector problem”. The relevant Government minister apparently did not even deign to discuss the mounting problems at Southern Cross with its CEO.

7. Despite the fact that Four Seasons is heavily taxpayer-supported, its holding companies are hidden from view (like so many other companies in the sector) in off-shore tax havens in the Cayman Islands and in Guernsey. GMB research has found that many of the landlords of ex-Southern Cross homes are similarly based in tax havens. Again, this is completely unacceptable.

8. GMB has called on the Care Quality Commission to establish whether Four Seasons has the financial stability to avoid becoming the “Son of Southern Cross”. At present, however, the CQC is reported by the Daily Telegraph as saying it is “not in a position to come to a conclusion”.

180 Christopher Thompson and Simon Mundy, “Four Seasons in debt refinancing talks”, FT, 4 October 2011.
Ev w106  Health Committee: Evidence

HOME CLOSURES

9. The new operators of Southern Cross homes are now assessing their operations. As recently as September, the Minister for Care Services Paul Burstow wrote of the break-up of Southern Cross:

“…no homes will close while the restructuring is ongoing. After that, we will see the market operating as usual. There have always been entrants and exits and we must expect that to continue. Once the restructuring is completed, new operators and landlords will no doubt think about the long-term viability of all the homes in their portfolio, and may decide to close some homes”. 176

So the Government looks forward to business as usual. This position is as abhorrent as it is out-of-touch with what the bulk of citizens want. Care homes are not an ordinary business, and elderly and vulnerable residents are not packages to be bought, sold and moved about.

10. Home closures are indeed very likely. These closures will in most cases be financially driven, with profit-maximisation taking precedence over the needs, welfare and longevity of residents. They may have dire consequences for the elderly and vulnerable people in the affected homes, given the known risks of premature death associated with forced moves. 177

11. It would be over-optimistic to assume that short-notice company failures and consequent home closures could be managed in line with the best practice laid down in the recent ADASS guidance, “Achieving Closure”. The ADASS document concludes that:

“[I]t is crucial that local authorities have the time and space in order to [put in place good-practice measures]… While all these can be built into a planned home closure, it would seem important that any emergency closures try to follow the same emerging good practice if at all possible.”

Subsequent guidance on short-notice closures published by the Social Care Institute for Excellence, in conjunction with ADASS, similarly relies for mitigation of the damaging effect of closures on residents on “good consultation and planning”. Unfortunately, “time and space” and “good consultation and planning” are the very ingredients in shortest supply in emergency situations. The ADASS guidance does acknowledge that “If a national chain of care homes were to fail… the scale and pace of the actions required could have extremely negative consequences for older residents (if not handled well).” This is, of course, all about dealing with the symptoms of failure, and not addressing—and stopping—the causes.

12. In the case of Southern Cross, lenders and landlords came to a behind-the-scenes agreement to avoid closures during the company’s break-up. This was, in truth, the only thing that has ensured even the short-term security of residents. It is simply not acceptable to bet the welfare of residents caught up in any future care-home failure on the unpredictable outcome of discussions between anonymous organisations meeting in secret in smoke-filled rooms.

13. That further corporate failures are likely has been publicly acknowledged. Nick Leslau, the commercial property magnate and Southern Cross landlord, commented on the Today programme on 7 October:

“Because a lot of these are special purpose vehicles that have taken over, I hope that we’re not storing up for a second Southern Cross or ‘son of’ in due course... [I]f the funding isn’t available in those homes or if something external happens, then you could have the same problem again.”

THE DEPARTMENT OF HEALTH’S DISCUSSION PAPER

14. The dangers of corporate failure in a care setting are beginning to penetrate official circles. The recent National Audit Office report, “Oversight of user choice and provider competition in care markets”, acknowledges that “the recent financial problems faced by Southern Cross illustrate the need for Government to develop a system to address serious provider failure”.

15. The Department of Health’s discussion paper, “Oversight of the Social Care Market”, has since tentatively tabled measures to improve (or one might almost say, commence) the financial regulation of care-home operators. The proposals around pre-contract auditing, ongoing checks, triggers for highly leveraged transactions, and posting of capital upfront, are broadly to be welcomed. Whether there is the political will to follow them through remains to be seen.

16. GMB will respond to the paper in due course; we will advocate the maximum possible regulatory safeguards. Fundamentally our view is that the care sector was never suitable territory for market mechanisms in the first place, and the Government and local authorities ought now to consider alternative models of providing residential care.

17. The Government’s discussion paper does nothing to assist in the short-term medium-term with the possibility of a crisis at Four Seasons or any other care-home provider chain, which would require urgent attention and possible intervention. The warnings over Southern Cross were ignored, with serious consequences. Have those lessons been learned?

176 Paul Burstow MP, Letter to Emily Thornberry MP, undated.
THE DILNOT REPORT

18. The Southern Cross debacle has highlighted the desperate need to get adult social care back on a firm financial footing. GMB is pleased that the Dilnot Commission recognised that the current system is not fit for purpose, but its recommendations are far from straightforward.

19. It doesn’t look to be as simple as saying, “there will be a cap”. In reality, the Dilnot report seems to be separating care into three components and setting a different funding arrangement for each: (a) “capping the lifetime contribution to adult social care costs that any individual needs to make at between £25,000 and £50,000”; (b) that “the asset threshold for those in residential care beyond which no means-tested help is given should increase from £23,250 to £100,000”; and (c) that people in residential care should pay £10,000 per annum “maximum contribution” “towards their general living costs”. This leaves a very confusing picture for those who might need elderly care in the future and those expected to provide it. It will only add to the confusion surrounding care-home and domiciliary-care companies.

20. GMB made the case to the Commission that what the British people want and deserve is a national care service equivalent to the NHS, free at the point of use and funded by general taxation. Most of the respondents to the Commission’s own canvassing started from this position. The Commission looks to have well and truly balked on that.

21. GMB also made clear to the Commission that the money you put into social care is only one side of the story. Much public money has been leaking out of social care as an after-effect of the privatisation of much of the sector, not least because of excessive debt financing.

DOMICILIARY CARE

22. The crisis in Southern Cross has to some extent obscured from public view the growing difficulties of the domiciliary-care sector, where there is ever-tightener rationing of eligibility and fragmentation of services.

23. In our response to the Dilnot Commission, GMB advocated “levelling-up” adult social care to the level of the NHS through funding reforms that would promote their closer integration. We also called for comparable investment in the workforce. The prevailing pro-market slant of public policy around personalization and direct payments, however, is going to make any sort of integration more and more difficult to achieve. The fragmentation of domiciliary-care provision in the interests of market “plurality” risks casualising the workforce and exacerbating regulatory weaknesses. A recent assessment of personalisation comments that “there is little hard evidence that this new scheme addresses the needs of most older people”.

THE LAW COMMISSION REPORT

24. GMB shares the Law Commission’s view that “it is essential that the law is clear about basic minimum entitlements to services”. In our opinion, the eligibility threshold should be the same in each local authority, to put a stop to the well-documented “postcode lottery” in care.

25. GMB notes the Law Commission’s recommendation that direct payments be extended to cover residential accommodation. We see potential pitfalls with this. Individual users lack bargaining strength. They and their families would find themselves under increasing pressure to raise money to top-up their allocated funding, especially since in the current climate any local authority cap is likely to be set at barely a subsistence level, and may not be sufficient to tempt operators.

26. GMB members know from first-hand experience that people want a quality care home in their locality. The existing system is already meant to include choice of accommodation. The actual problem is that real funding levels are heading downwards and indebted care home companies are spending income intended to pay for care on servicing their debts. We are concerned that direct payments represent a further extension of market arrangements in a sector where the market has performed dismally.

CONCLUSION AND RECOMMENDATIONS

27. Since the Credit Crisis began, care-home operators such as Southern Cross and Four Seasons have had to contend not just with public-spending cuts, but also with the after-effects of financial engineering. Speculative deals in the boom years by private-equity groups and others, attracted by the prospect of capturing supposedly secure, publicly-funded income streams, has yielded up unsustainable debts and liabilities. The Southern Cross debacle demonstrates how handing over the care of vulnerable and defenceless people to the private sector has opened social care up to financial exploitation. GMB deplores the fact that recipients of care now risk paying the price for the failure of high finance. Lessons must be learnt.


28. To that end, GMB calls for a root-and-branch review of social care, to include:

— A public inquiry into the background to the Southern Cross debacle, to establish who profited from the financial engineering, including landlord links to tax havens. Those who made a killing out of Southern Cross should take a “hair cut” in the form of a levy.

— Introduction of security of tenure for residents. Residents, their families and staff all crave long-term stability, yet at present residents appear to have less right than squatters to stay in their homes. Indeed, perversely, the most vulnerable and dependent members of our society have the least rights and protections, even though it is fact that moving them can kill.

— An end to the “postcode lottery” in care, with an adequate national statutory minimum entitlement to domiciliary and residential care.

— After more than 20 years of failed privatisation, measures to take all care homes out of private-sector ownership, so that profit never again takes precedence over care. It is surprising that the Government has not so far applied its interest in social enterprises to the residential care sector.

— For as long as care homes remain in private hands, an end to the lack of financial accountability of care-home operators and their landlords, by means of the following:

— Legislation to require that those companies who receive taxpayers’ money in order to house and care for UK taxpayers are registered in this country, pay taxes in this country, and “open their books”. If local authorities must publish all spend over £500, so that taxpayers can see where their money goes, why not also the care industry?

— A new, independent and “fit for purpose” public regulator sufficiently resourced, and with the necessary legal powers, to conduct financial checks and due diligence on care home operators and undertake a comprehensive inspection regime backed by statutory minimum standards and staffing levels.

29. Urgent attention and intervention by Government is required to ensure Four Seasons—or any other care-home chain—does not become “the son of Southern Cross”.

October 2011

Written evidence from Bupa (SC 46)

EXECUTIVE SUMMARY

— An quality rating system is required which does not just simply relate to essential standards and which older people and their families can readily and quickly understand.

— A system of fair fees is required.

— There should be greater integration between the NHS and social care.

— Implications of the Southern Cross scenario for the sector.

INTRODUCTION

Bupa commends the Committee’s call for evidence and welcomes the opportunity to respond. This response builds on our response to the Social Care Green Paper consultation in 2009, and the following works:

— Bupa Care Services/PSSRU analysis of length of stay.

— A summary of Bupa’s previous long-term care insurance products.

— Incidence rates and probability of lifetime risk, prepared by Bupa Health Assurance.

— Data on length of claim.

— PSSRU costs of care calculation (including hotel costs).

— Bupa Care Services international census summary.

— Bupa’s response to the call for evidence by the Commission on Funding of Care and Support.

As the above indicates, we have worked closely with and funded a number of diverse projects with external organisations and gather data to inform the social care debate. In line with the committee’s instructions we have not annexed these documents. Copies can be provided on request.
Our Response

In addition to the observations and views contained in the above documents, there are four areas which, in our opinion, need further consideration by the Committee:

A. The establishment of a workable system of quality ratings to replace star ratings

The Care Quality Commission (CQC) is currently consulting on a new rating system for indicating assessments of quality of care homes in England. Our response stressed the importance of:

— learning from the shortfalls of the former rating system when developing any new system; and
— creating a system which older people and their families can understand and use to judge a care home’s service.

The CSC’s proposals so far have centred simply on meeting their Essential Standards of Quality and Safety for care homes in England (ESQSs). This system assesses whether the ESQSs have been met, if not an establishment will either not be registered or will be required to take action to achieve the required standard.

Our experience of supporting people who are seeking care home places shows that unless a new rating system looks at factors over and above the ESQSs, it will have no useful purpose for older people and their families.

There were many advantages to the previous system which was discontinued in October 2010. It used the now-suspended KLORA (key lines of regulatory assessment) which were established by the Commission for Social Care Inspection (CSCI).

The system used for the “star ratings” looked at more than just compliance with the Minimum Standards. Its ratings of “poor”, “adequate”, “good” or “excellent”, proved effective in driving up quality in the sector and were relevant to older people. Even so, there were ways that the system could have been improved. A rating of adequate implied that the service was below the acceptable standard. This interpretation was exacerbated by the fact that local authorities are judged on the numbers of good and excellent service providers they commission. This issue has been acknowledged and addressed by OFSTED which rates a service, equivalent to “adequate”, as “satisfactory” a clearer term.

In addition, KLORA contained very general statements about what a service might look like; hence gradings awarded could be very subjective. The new system needs to provide more objective benchmarks that can be used to determine the grading and to check whether the award is accurate. At the moment there is nothing which can be used to assess objectively whether an inspector has awarded the appropriate grade. These benchmarks could also ensure that all providers are assessed consistently without judgments being influenced by the size of the organisation, or preconceived perceptions.

By comparison, the Scottish system has a greater number of categories with each general quality area divided further. The “adequate” grade (grade 3) applies to performance at a basic level where most aspects of the Quality Theme/Statement are met and aspects which are not met may be subject to recommendations but don’t cause concern. The “excellent” grade (grade 6) is awarded only where all aspects of the Quality Theme/Statement are met or exceeded and the service is exemplary. This has the advantage of making the Scottish system a more accurate and analytical process but it is quite complicated to follow.

We believe that the CQC is best placed to run the new system as they are already assessing compliance with the ESQSs. There is a need for the new system to be established as soon as possible to add stability in an area which has seen many changes in recent years.

The ideal for a new system, would be a system more prescriptive than the KLORA, but less complicated than in Scotland. It would also include categories and descriptions that are relevant to older people and their families, while also incentivising and recognising excellent care homes. Such a system would allow older people and their families to confidently compare providers and to locate care homes which fulfil their particular needs and wishes.

As we have said, a new system needs to look further than the ESQSs to be a useful resource. It also needs to clarify exactly where a service meeting all the ESQSs falls on the scale, ie where is the bottom line. It then needs to be explicit in setting out the factors that would decide whether one provider is better than another, ie which outcomes will be targeted and what performance measures are needed to achieve a rating better than the bottom line. Additionally, more emphasis needs to be given to focussing on what the service does well and what has improved since last inspection.

B. Funding of Social Care: Fair fees

We know that many people are living longer which means that people are entering care homes at an older age and more frail than ever before. Bupa’s most recent international census of the dependency levels of residents in its care homes in Australia, New Zealand, Spain and the UK, showed that:

— 62% are living with the effects of dementia, stroke or Parkinson’s disease;
— 48% are immobile; and
— 94% have a clinical reason for seeking a residential care home place.

In 2003, Bupa care homes in the UK looked after just under 4,000 people who were living with dementia, in 2011 this figure is close to 7,000 and rising.

To provide aged care of the standard that meets this higher dependency level, there needs to be a public acceptance that investment is needed to continually train and develop staff, research new and innovative approaches to care, upgrade existing facilities, and build modern care homes that can cater for the individual needs of older people.

The Dilnot Commission’s proposals, whilst interesting in the areas considered, would not result in more money coming into the system as it substituted one source for another. Private contributions are to be replaced with state-funded tax payer money, but additional funding is required for those who are unable to provide for themselves. The Dilnot Commission did point to current underfunding of the system and said that more public money is urgently required.

Early in 2011, Bupa published Who Cares?, a report that highlighted the ongoing problems caused by local councils in England paying fees that were below the real cost of providing care for older people. It predicted that, unless action is taken to reverse this trend, a combination of home closures and increased demand would mean up to 100,000 frail older people being unable to access care home places that they need.

Given the increasing level of dependency of people living in care homes, it would be likely that those unable to gain a place would instead turn to the NHS for their long term care, creating a bed-blocking crisis for hospitals.

At the same time regulators and others are raising concerns about standards of care provided in residential homes and want to see greater investment in staff training, more activities, better equipment and even more modern facilities.

Further research undertaken for Bupa also shows that the current average residential care fee of £461 paid by local authorities does not cover the costs of simply meeting the CQC Essential Standards of Quality and Safety for care homes in England.

Local authorities are currently offering fee increases of just 0.3%, in real terms a reduction. This comes after previous years of below-cost fee increases in which operators have already worked to identify efficiencies that do not compromise care as their major costs continue to rise.

The research carried out for Bupa shows that, to fill the gap caused by previous years of under-funding and cover the costs of meeting (not exceeding) CQC Essential Standards, local councils in England would need to raise the average weekly fees they pay by between 5% and 8% per year—an increase of up to £41 per person per week each year—between 2012–13 and 2014–15, depending on the type of care being provided.

We also believe that councils should promote and reward investment in providing quality care by paying higher fees where standards are being exceeded.

As fees are set individually by councils, the increases would vary widely, depending on the fees they currently pay.

Recent pressure on public budgets has exacerbated the issue. We already see instances when local councils pay more to their own homes for aged care than they will pay to a private provider. Now we are seeing many of those local authorities which still run homes announcing plans to close them as they can no longer afford to maintain and run them. There is an expectation that private care homes will be able to provide places for their existing and future residents.

We estimate that to redress the existing shortfall, for England alone, would require an extra funding of between £286 million and £294 million year on year in each of the three years from 2012–13 to 2014–15. The annual increases would mean an extra £865 million per year being spent by 2014–15 compared to 2011–12.

C. Promoting integration between the NHS and social care system

While Bupa believes that care homes and hospitals face different challenges, and should be considered separately, we want to see even greater integration between the NHS and the social care system so that older people are not disadvantaged by unnecessary boundaries that slow discharge from acute hospital wards and hamper the exchange of information such as patients’ medical notes.

Greater integration between health and social care would also enable care homes to make a greater contribution to some of the challenges facing the NHS.

In many cases acute hospital wards are not appropriate for the long-term care of older people with chronic conditions and NHS staff and facilities are not equipped to do so. Such people can be looked after far more effectively in residential care than the NHS, yet older people remain in hospital beds longer than necessary as they are unable to return home because adaptations are needed or community-based services are not available. Greater use of nurse-led home healthcare and care homes can help the discharge of older people to a community setting which is more appropriate to their individual needs and helps the NHS use its resources more efficiently.

http://www.bupa.com/about-us/information-centre/uk/who-cares
Councils should work with the NHS to improve the integration of health and social care systems and budgets. Local Government should build further on its initial steps so that integrated plans can be developed that cross “budget borders” in developing alternative care solutions for older people.

Local councils must pledge to pass on in full the £2 billion allocated to adult social care by the Government.

D. Southern Cross implications

Our view is that further regulation of the social care sector, following the collapse of Southern Cross, is not necessary and would not work in practice. For the sake of transparency, it’s important to point out that while we were approached in relation to taking over some of the Southern Cross homes, we have chosen not to do so.

Whilst it would be in the interests of the sector and care users for there to be fewer instances of operators getting into financial difficulty, we believe that there is already sufficient regulation in place and we disagree that the sector is lightly regulated. It is quite rightly, as a result of the previous government’s actions, regulated to the same detailed standards as the NHS.

We recognise that there may be a need for improved market intelligence and monitoring of providers, such as better information sharing and greater analysis of provider performance, as suggested in a recent Department of Health consultation. But we disagree that there is a requirement for improved post-failure regimes such as changes to insolvency or the risk pooling of funds among providers.

It now appears clear that homes operated and residents served by Southern Cross will, in the vast majority of cases, be transferred to new operators with no interruption in care. It may be that a small number of homes which are too expensive to bring up to current standards or in areas where there is an excess of residential care beds will close. But the overall transfer has been successfully managed with no need for direct government intervention, financial or otherwise, in contrast with other sectors.

We believe that provided operators can generate a reasonable return from providing care to support and invest in their homes, operators will always step in to take over homes from an operator who (as was the case in Southern Cross in our view) over extends themselves and, while generating a surplus from operations, cannot fund the payments to their lenders or landlords to which they may have committed themselves. This may not be the case, however, in future if thinly capitalised operators have their margins squeezed yet further through real terms reductions in fees.

October 2011

Written evidence from Independent Age (SC 47)

SUMMARY

1. Independent Age is aware from its experience of supporting older people, their families and carers that the current system of social care and its funding needs reform. It is confusing, complex, inequitable and inconsistent.

2. We welcome the core recommendations in the Dilnot and Law Commission reports. Their implementation will help to address some of the problems with the current system. However, we believe that further measures are needed if the national eligibility threshold is set at “substantial”. There is a need for greater integration of health and social care budgets and greater investment in low level support for older people to prevent or delay the need for more intensive intervention.

3. We also consider that in order to achieve portability, local authorities should be required to provide a package of care designed to achieve the same outcomes for the older person as that provided previously.

4. Both the Dilnot and Law Commission reports attach significant importance to the provision of better information and advice on social care. We support this emphasis, since we believe it will be fundamental to the success of social care reform.

5. We consider that, as recommended in the Dilnot report, there is a compelling case for the development of a new information, advice and support architecture for older people. A strategy should be developed, informed by current good practice, as the basis for a holistic, high quality service at the national and local level. We focus on this area in our submission.

INTRODUCTION

6. Independent Age has recently merged with two other older people’s charities, Counsel and Care and Universal Beneficent Society, to provide a broader range of services than any of the charities could provide separately.

7. The merged charity, which is called Independent Age, provides national information and advice service for older people, their families and carers, focusing on three vital areas:

— social care, including care at home, in hospital and residential care;
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— welfare benefits;
— befriending services and other social support;
— this is integrated with local support, including;
— practical help with forms, assessments and other issues; and
— one-to-one and group befriending schemes.

8. We use the knowledge we gain from providing our services to help influence policy and practice, and it is in this context that we are responding to the Committee’s enquiry.

PART 1: IMPROVING SOCIAL CARE FOR OLDER PEOPLE

9. Independent Age knows from its experience of working to support older people, their families and carers that reform of the current social care system is urgently needed. It is confusing, complex, inequitable and inconsistent.

10. Confusing and complex. It is extremely difficult for older people and their families to understand and navigate the care system. A Counsel and Care survey conducted in 2008 found that over 51% of people found the system of social care confusing\(^{181}\) while another survey conducted in 2010 by Counsel and Care found that just 5% of people considered that it was easy to navigate. 79% in the same survey, thought that not enough was done to tell people about the care options available.\(^{182}\) While, in other research looking at people “in the system”, 39% said it was difficult to understand what was free and what had to be paid for.\(^{183}\)

11. Inconsistent and inequitable. The experience of the older people who use our services is that there are too many inconsistencies in service provision. Local authorities have different eligibility thresholds for access to care. This means that older people with moderate needs receive support in some areas but not in others. Nationally, there is also an unduly low savings threshold set for access to local authority support, unduly large deductions made from income when older people have savings and an unduly small amount allowed for essential items in care homes.

12. We have included in the Appendix a number of actual cases (anonymised) recently dealt with by the Counsel and Care, that demonstrate the confusion, complexity, inconsistency and inequity of the current system.

Reform is needed to create a new care and support system that is:

13. Sustainable—a sustainable solution is required, which both helps older people to retain their independence and access support which meets their needs. This means taking a long-term view and making adequate investment in low level support, and in information and advice to facilitate access to it.

14. Personal—older people should have the same level of choice and control over their care and support regardless of whether they live at home, in a care home or supported housing. Access to high quality independent information, advice and support, which is tailored to individual circumstances is key to ensuring that older people retain control and are able to navigate the system effectively.

15. Simple—the complexity of the current system means that older people do not understand their rights and neither in some instances do local authorities and PCTs appear to understand their responsibilities. In one recent case, Counsel and Care demonstrated that an individual had wrongly had to pay out over £67,000 for care that should have been funded by the local PCT as continuing care.

16. Flexible—the new system should be flexible enough to provide care which meets individual needs, and to encourage innovation, within the context of a new national approach to eligibility.

17. Portable—our experience is that when older people with care needs move to a new area, including to a different care home, they often struggle to maintain the same care package and level of funding from the local authority. This can make them fearful of moving nearer to family members.

18. Inclusive—there is an ever growing gap between those who can access the system and those who can not. Many local authorities are now only providing services to those with critical or substantial needs. As a result a significant number of older people are left struggling to manage independently.

19. Independent Age and Counsel and Care support the core recommendations in the Dilnot and Law Commission reports because we consider that their implementation will help to address many of the problems with the current system. Pulling all the legislation into one statute, as recommended by the Law Commission, will bring much needed clarity on the rights and responsibilities of both the individual and the state, as too will Dilnot’s recommendation for a cap on the amount that older people are required to spend on their care. Dilnot’s proposal for nationally-set eligibility criteria will also help to remove some of the inequity in the current system. However, we think it important to note that:

\(^{181}\) Counsel and Care, Carers UK and Help the Aged (2008) “Right care, Right deal Scary, depressing and confusing: Voter’s view of Social Care revealed”.

\(^{182}\) Counsel and Care (2010) “Exclusive Research Reveals Widespread Confusion over Care for Older People”,

20. There is potential for confusion about the notion of a £35,000 “cap”. Users will need to understand that this is a notional amount based on the figure that an individual council would be prepared to pay for an individual’s care, not a reflection of actual amounts spent by that individual. Nor does the £35,000 cap remove the need for additional expenditure on accommodation costs and any top-up fees that an individual might choose (or might need) to pay.

21. Setting the threshold at “substantial” creates a risk that those with “moderate” and “low” care needs are not properly supported and prevented, where possible, from developing “substantial” and “critical” needs. This is not only unreasonable for the people involved but also potentially more expensive: The Joseph Rowntree Foundation have identified the value in providing older people with a range of less intensive support such as befriending, shopping, cleaning and laundry has in maintaining independence, enabling them to live at home for longer.\(^{184}\)

22. The proposals for standardised assessment, or common assessment framework, and nationally set eligibility criteria will go a long way to encourage greater portability in care and support, but may not go far enough because while local authorities might accept another’s assessment, they might choose not to provide comparable services. The challenge here is in maintaining consistency of interpretation. Our recommendation is that local authorities are required to ensure that the wellbeing of the older person and the outcomes sought will be achieved by the new services offered.

23. The Dilnot report refers to the importance of better integration of health and social care. Better partnership working is required between social care, health and housing with more pooled resources, joint decisions and integrated budgets. This would both improve the experience for older people and reduce duplication and waste. Investment by the health service in preventative measures would reduce acute admissions and ultimately save money across the system.

24. Both the Dilnot and Law Commission reports attach significant importance to the development of a new improved system of advice and information for social care and its funding. Independent Age welcomes this emphasis, since we believe such an improvement will be fundamental to the success of social care reform, and we focus on this in the rest of this submission.

25. We believe that the firm and coordinated directives for change made by Dilnot and the Law Commission must be taken up by government and implemented with intent.

**Part 2: Information, Advice and Support**

26. We believe that discussion of information and advice needs in the context of social care often conflates several different needs, subject areas and types of user. We believe it is essential to segment the market in order to understand it, and we suggest that this segmentation should be in two ways—firstly by the type of advice and information required in the context of social care and secondly by the type of user.

*Types of advice*

27. Users or potential users of social care services need three types of information and advice. They concern:

28. Rights and entitlements to statutory services—what can the user expect from his or her council, from national government etc?

29. Options for finance and funding—if the user needs and/or chooses to spend more on care services, what personal options are there for funding this expenditure?

30. Quality and choice—what service options exist for the user and how do they rate in terms of quality etc?

31. The range of this advice and information need suggests that a strategy to address it will have to involve a very wide range of stakeholders, from government to charities, councils, insurance providers, independent financial advisors etc.

Types of user

32. We identify five different types of social care service user, each with different needs. This is shown in the diagram below:

- **Future users**: This group are not currently using services, but have a potential need in future that they may not have considered or planned for (this covers most if not all adults not in one of the categories below).
- **‘Emerging’ users**: This group are not currently using services but have an immediate need (for example, following a sudden illness). This group is particularly vulnerable because they are often seeking help at a time of great stress and urgency.
- **Current self-funders**: This group consists of those who are currently paying for their own care services. They are particularly badly served at the moment.
- **Current funded service users**: This group is probably the best served at the moment because councils have a statutory duty to provide advice and information.
- **Current personal budget holders**: This group has information needs over and above those of other funded service users. They need additional help and support to spend their budgets effectively.

33. Information, advice and support needs to be improved for all these groups but particularly for those in the inner four rings and their families and/or carers:

34. To prevent crisis and save individuals money, stress and restricted choices and reduce expenditure on intensive health and social care services (see the box below).

35. Dr Emma Burgess, commenting on her work on the FirstStop evaluation:

   “People often end up needing to go into an expensive care home after an accident such as a fall. This puts pressure on the public purse and more importantly it can be a terrible emotional and financial wrench for the people who have to move and their families. But in many cases this could have been avoided if they had received good advice which had supported them in making simple adaptations to their home and helped them to plan ahead.”

36. To enable a new market for care services to develop, underpinning the use of personal budgets and potentially facilitating access to a wider range of more responsive services.

37. To ensure carers make appropriate choices. For example, in some instances, carers have given up their jobs without realising that they have a right to work flexibly.

38. As a core element of protection particularly for vulnerable older people.

Problems and issues

39. There is a general consensus that current provision is inadequate. The Health Committee report on social care published in March last year quotes evidence from the Parkinson’s Disease Society to the effect that there is: “poor information provision and signposting to services, especially with regard to signposting to social care support”. While Dilnot concludes that:

40. “Provision of information and advice is poor, and services often fail to join up. All this means that in many cases people do not have a good experience.”

41. We have suggested above that this is particularly true for some specific groups of older people. For example, research undertaken by Henwood and Hudson indicates that self funders “often appear to exist in a parallel universe to that of people who meet the eligibility criteria for council funded service.”

   It suggests that there are often serious shortcomings in the information, advice and support available to them (see below).

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185 From the Mature Times website: “Growing demand for older people’s advice service points to need for broader culture shift”, 22 March 2010.

186 Improvement and Development Agency—IDeA; Association of Directors of Adult Social Services—ADASS; Local Government Association—LGA; Social Care Institute for Excellence (October 2009) A parallel universe? People who fund their own care and support: a review of the literature; and Navigating the parallel universe: information and advice for people who self-fund; by Hudson and Henwood.
42. Similarly, a recent report published by IPPR says that “the development of choice and personalisation in social care has not been accompanied by an adequate supply of information.”

43. Another significant issue is the number of older people who are socially isolated and who need social care but are not in contact with any services.

The current system of advice, information and support can best be described as:

44. **Fragmented**—There are many high quality national and local providers of information and advice but there is no clear route in and individuals have to approach a number of different organisations in an attempt to get their needs met. Many services are also being reduced in scope or scale because of funding cuts.

45. **Partial**—There are gaps in the provision of impartial and independent advice for example, the financial aspects of owner occupation and financial products, for low income, older home owners.

46. **Uncoordinated**—There are very valuable initiatives such as FirstStop (Counsel and Care is a service providing partner) and Moneymadeclear but these services do not join up nationally.

**Local authority responsibilities**

47. Local authorities are an obvious port of call for the provision of high quality information, advice and support at the local level.

48. Our understanding of the current legislative and policy framework is that local authorities have a statutory duty to provide information to those “in need of support”. However, evidence from research undertaken by Henwood and Hudson suggests that they define this group quite narrowly ie it is those for whom the local authority has a statutory duty to provide services. However, this runs counter to statutory guidance to local authorities which says:

49. “The development of accessible and universal services will be vital for those individuals and their carers whose needs do not meet the council’s eligibility criteria but who still need access to support in order to maintain their independence and well-being. In particular, everyone should be able to access high-quality information and advice to point them in the right direction for help.”

50. It also contradicts the concordat developed by central and local government, regulatory bodies and service providers which set out “a shared vision and commitment to the transformation of adult social care” based on early intervention and re-enablement, personalisation and information, advice and advocacy. The expectation was that “local authorities would provide universal information, advice and advocacy services for all who need services and their carers…. irrespective of eligibility for public funding” by April 2011. While there are some notable examples of good practice, generally progress appears to have been extremely patchy. Research undertaken by Opportunity Links last year found that 40% of local authorities had not yet developed a strategy for delivering universal information and advice.

**Developing an appropriate response**

51. There is general agreement that the current care system is difficult to navigate, this is in part due to its complexity but it is also because there is insufficient support available to help people make choices. On this basis the Resolution Foundation argues that:

52. A new navigation service must be a central component of a new care architecture, supporting people at every stage, building upon but most importantly coordinating and extending the reach of the existing advice sector.

53. They argue that this new service should take the form of a “first stop shop” at national and local level providing a holistic service across the range of issues on which older people require advice; housing, benefits, social care, finances, social support etc.

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188 Housing Associations Charitable Trust, HACT (April 2011) Fit for Living: Information, advice and practical help for older people in a new age of localism.

189 See footnote 186.

190 Department of Health, DOH (25 February 2010) Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care—guidance on eligibility criteria for adult social care.

191 Local Government Association—LGA, the Association of Directors of Adult Social Services—ADASS, the NHS and others (2007) Putting People First

192 Cited in the Demos blog Taking a gamble on long term care: http://www.demos.co.uk/blog/takingagambleonendoflifecare

54. Such a navigation service could build on FirstStop which offers a single access point to a range of providers of information and advice services. It is distinctive because basic information collected from callers is shared between partners so that individuals only have to provide it once.

55. While government at the central and local level has a key role to play in developing and funding such a new service, our contention is that it would have more credibility if it were provided by independent organisations (without a gatekeeping or rationing role in relation to statutory services or funding).

56. While web-based and telephone information and advice services have a valuable role to play, our experience is that older people prefer to receive information face to face from people they know and trust. IPPR argues that a new “community information infrastructure” needs to be built. It suggests that an emphasis should be placed on peer support, enabling older people to learn from each other’s experiences (an approach used by Independent Age).

Other approaches which might be replicated are:

57. “First contact” systems for example, “First Contact” in Nottinghamshire. When a partner agency visits an older person at home, they complete a checklist of needs such as, advice on benefits or support to prevent falls. Responses are reported back to a central contact, who coordinates referrals to partners.

58. Successful models of outreach. For example, that developed by the Cheshire Fire Service which entered into an agreement with the PCT to access information about older people in its area so it could undertake fire safety checks. It developed a simple contact form with Age UK Cheshire which enabled assessment of older people’s needs before they reached a critical condition.

59. The models and approaches sketched out above suggest that there is much good practice on which to build.

60. Independent Age considers that, as recommended in the Dilnot report, there is a compelling need for the development of a new information, advice and support architecture for older people and that a strategy should be developed, informed by current good practice, as the basis for a holistic, high quality service at national and local level delivered by a range of agencies. We urge the Health Select Committee to address this issue in its report.

October 2011

APPENDIX

RECENT CASES RECEIVED BY COUNSEL AND CARE DEMONSTRATING PROBLEMS WITH THE CURRENT SYSTEM

1. An elderly woman, Mrs C (86), diagnosed with dementia and previously receiving social care services in her home, was admitted to hospital for eight weeks and assessed as needing 24-hour care. However the council offered only a care home a long way from her daughter. The woman’s daughter moved her mother into closer accommodation but found she could not afford the fees. The council has refused to help as the home is more expensive than their original choice. Counsel and Care advised the daughter that placement should take into account social factors such as the need for proximity to family and the daughter filed a formal complaint that was not upheld. The daughter has since taken the matter to the local ombudsman.

2. A local authority agreed to pay care fees for 12 weeks for Mrs P, who is moving into a care home and has put up her home for sale. However the local authority then asked that the 12 weeks fees be paid back once the property is sold. Counsel and Care advised that the council could not legally require the money to be repaid as this only applies if the property is sold within the 12 weeks.

3. Ms R was concerned that her father’s care visits had been reduced from three visits per day to one without a reassessment of need. Her father is blind in one eye and had just come out of hospital. He is unable to cook for himself. On the day of Ms R’s call, the care worker had not arrived at her father’s home.

4. Mr B emailed us about his mother, who had been moved from a care home in one local authority to another in a different local authority and had spent all her savings and accrued over £20,000 debt in care fees. In our view the original council had misinformed Mr B about their funding responsibilities.

5. Mrs T called us in distress because she had been told she would have to top up her husband’s care home fees, which she was unable to do. Due to her husband’s increased care needs he was obliged to move to a more expensive home. The council were not able to provide information on less expensive homes that would meet her husband’s increased needs, nor were they willing to increase the rate that they pay.

6. Ms B called us about her mother (90), who was admitted to hospital after a fall. It has been agreed she should move into a care home but the one chosen by the family, from a list supplied by the council, costs more than the council’s standard rate. Ms B was asked to pay her mother’s top up fees during the initial 12-week period because she was wrongly told by the council that her mother could not pay the difference from her own savings.

IPPR (October 2011), Older Londoners, Clifton ed.
7. Mrs H called Counsel and Care for advice regarding her father’s situation as he was due to be discharged from hospital. A stroke had left him with severe mobility problems and he is doubly incontinent. Her father did not want to go into residential care and his hospital consultant believed that following a temporary stay in a care home his physical condition might improve enough for him to return home. The local authority was only able to propose a home care package of a few hours a day that would not met his needs. Eventually, Mrs H was able to agree a suitable home care package with the local authority but this was withdrawn at the last minute.

8. Mrs P’s 78 year old husband is immobile following a stroke 18 years ago. He receives home care from his local council. Mrs P contacted Counsel and Care to discuss a recent reassessment to see whether Mr P met the new criteria of “substantial” or “critical” needs. She explained that the social worker had acted in an intimidating manner and threatened to end the assessment if Mr P did not agree to self-directed payments, saying that there was no choice. They both found the assessment very exhausting—at over three hours.

9. Counsel and Care was contacted by Mr G, whose wife had recently moved to residential care. The Mr G explained that on the advice of a financial advisor that he had moved all of his savings into his wife’s names some years previously, but that the council was refusing to recognise his right to some of this money. In response Counsel and Care helped to draft a letter arguing his case with the council, who subsequently agreed that he should receive half of the savings.

Executive Summary

While our research shows personal budgets are bringing tangible benefits to many of those who use them, the successful roll-out of personal budgets requires a number of issues to be looked at:

- **Training and support for staff implementing personal budgets.** Staff’s concerns around value for money, safeguarding, and budget misuse need to be addressed so staff can confidently promote personal budgets.

- **Ensuring that personalisation is accompanied by an increase in choice and control.** In some local authorities, users recorded as in receipt of a managed personal budget are not being offered choice and control over their care, meaning the roll out of personal budgets is unlikely to generate the expected benefits. Our research indicates that only direct payments offer real choice and control.

- **Developing local providers’ markets.** While local authorities are working with providers to ensure users can have a choice of suppliers, changing commissioning practices takes time. These changes in commissioning practices have significant implications for providers, and local authorities need to inform the local market to ensure there is adequate supply to meet the demand. Most importantly, the growth in the number of personal assistants needs to be accompanied by training and regulation to safeguard both employers and personal assistants themselves.

- **Access to support planning.** Effective support planning is a key success factor. Those who access it tend to use their budget in a more tailored and personalised way, and appear to achieve better outcomes. However, access to support planning is still patchy.

- **Information, advice and support for users of personal budget.** These are crucial to enable users to get the most out of their personal budgets, and mitigate the risks associated with personal budgets. They are also important to increase the take-up of direct payments. However, information provision is sometimes lacking, and the quality of the advice provided is not always consistent.

The Evidence

1. We welcome the opportunity to respond to the Health Select Committee’s call for evidence on social care. As a social and market research agency we have worked on behalf of a range of clients across the social care sector over the past decade to give users and staff a voice on the support they receive or provide. The evidence provided below draws on the research we have conducted, as well as on our understanding of the sector that we have built up over the years through our contacts with stakeholders.

2. We have particular expertise in the personalisation of social care. Our response therefore focuses on the practical and policy implications of the Government’s commitment to promote personalisation of social care, including personal budgets and direct payments.

3. Throughout our work we have come across many situations where personalisation has had a significant impact on people’s lives. Many disabled people and carers have spoken highly of their personal budgets when taking part in research, explaining that it gave them more personalised support, increased choice (of activities, or of suppliers), increased control (over the care and support provided, when, and by whom), and increased satisfaction with their care and support. We have also come across a few people for whom personal budgets had a negative impact, related to the poor quality of care received, and the stress, upset and confusion caused by inadvertent misuse of budget and problems with personal assistants.
4. Drawing on our research findings, we believe that a number of issues need to be addressed to make personalisation work for all users and carers, and enable a wider and successful roll-out of personal budgets. They relate to:

- Training and support for staff implementing personal budgets.
- Ensuring that personalisation is accompanied by an increase in choice and control for users and carers.
- Developing local providers’ markets.
- Access to support planning.
- Information, advice and support for users of personal budgets.

We detail each of these issues in turn.

**Training and support for staff implementing personal budgets**

5. Personalisation represents a significant cultural change for social care staff. This is a gradual process however. Staff across the country are slowly realising the importance and benefits of self-directed support for service users. While most staff across the sector know at least a fair amount about personalisation, the research we have conducted shows that the majority feel that they need more support to implement personalisation. Staff’s key concerns with regard to personal budgets are that:

- they make it harder for local authorities to fulfil their safeguarding responsibilities;
- they are prone to misuse; and
- they are less likely to offer value for money than block contracts or framework agreements—an important issue in a climate of budget cuts.

6. It is important to address these concerns because they are slowing down the implementation of direct payments. Training, coaching, mentoring, real case studies, and sharing of good practice, could help staff in adult social care learn about ways of promoting direct payments without a detrimental impact on safeguarding and budget misuse.

**Ensuring that personalisation is accompanied by an increase in choice and control for users and carers**

7. The work we have conducted for the National Audit Office has shown that personal budgets do not necessarily result in an increase in choice and control for budget users and carers. This is related to important differences in the way local authorities are implementing personal budgets. These differences are not adequately reflected by the National Indicator NI 130, due to inconsistency in recording practices between local authorities.

8. Few of the 48 participants interviewed in the above qualitative project recalled being offered a choice between the three types of personal budgets (direct payment, personal budget managed by their local authority or by a third party, or a combination of direct payment and managed budget). This means that some people may be opting for a direct payment because they want choice and control over their support, not knowing that a managed budget could in theory enable them to exercise choice and control and possibly be better suited to their circumstances.

9. That said, the reason for not offering users a choice between the different types of personal budget could be that in many local authorities, managed personal budgets do not currently provide service users with real choice. Our work for the NAO showed that the care provision of those recorded as receiving a managed personal budget often continued in the same way as it would have under the previous system, without the budget holder being aware that they receive a personal budget. Only direct payments seemed to offer users real choice and control over their care. It may be that local authorities are not yet in a position to offer a choice of suppliers to people on a managed personal budget, possibly due to their commissioning arrangements.

10. Overall, these situations mean that in some local authorities, the target to have all users of social care in receipt of a personal budget by April 2013 may not deliver the expected improvements for users.

**Developing local providers’ markets**

11. Users of personal budgets cannot really exercise choice if the market is dominated by one, or just a few, providers, which is a key issue in rural areas. While there seems to be a well developed supply of care agencies, there is a potential shortfall in the availability of less common types of services or providers. In our research we have come across some users of direct payments who only had one applicant when recruiting a personal assistant. In light of this, many local authorities are undertaking some work to develop the local providers market. However, they face many difficulties while doing this.

12. First, personalisation creates a very different business environment for providers of care and support services. Some local authorities have told us that they needed to educate providers about personalisation. Providers are required to adapt their working practices to the demand but they do not necessarily know what

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195 Users of social care personal budgets, Ipsos MORI report for the National Audit Office study on the Department of Health oversight of care market, September 2011

the demand is likely to be in the coming years as personalisation develops. Indeed, we have seen some research
evidence of users of personal budgets moving away from traditional services to use a wider range of suppliers,
and in particular venture further into mainstream services (which do not exclusively target users of older or
disabled people). Incidentally, these innovative uses of personal budgets also make the screening and
accreditation of suppliers more difficult for local authorities.

13. Second, local authorities have to reconsider their commissioning practices to be able to offer personal
budgets, putting an end to, or renegotiating block contracts or framework agreements. It is taking them time
to do so, and is also raising concerns among those leading on commissioning that personal budgets may not
provide value for money, compared with block contracts or framework agreements. Many local authorities
adult social care services have experienced budget cuts over the last 18 months, which makes value for money
even more critical than it used to be. This perception needs to be looked at in more detail as it may impact on
some local authorities’ willingness to really change their commissioning practices to offer a choice of suppliers
to recipients of personal budgets.

14. Users however, have expressed mixed views on value for money. In the research we conducted for the
NAO, some said they were able to get more hours of care with their direct payment than if they had continued
with the traditional service provision, while others said the opposite (which put them off from taking a direct
payment). Some users also reported difficulties in recruiting a personal assistant at the hourly rate they were
prepared to pay.

15. Those in receipt of a personal budget need information on suppliers, which is not always available. Our
study for the NAO showed that many users of personal budgets relied on word of mouth or on their social
workers as their main source of information to help them choose between different suppliers. Participants
wanted to see lists of potential providers with feedback from other users to help them choose. Online tools are
being developed by local authorities to address this need. However, many users of adult social care services
do not use the internet.

16. Finally, many people are choosing to use their direct payment to pay for personal assistants. However,
research we conducted in 2010 shows that there is little regulation, training or support for personal assistants.
The experiences from personal assistants and users of direct payment indicate that there needs to be some
structure in place to support the safe growth of the personal assistant role. Growth of the workforce without
this risks creating both a vulnerable workforce and vulnerable “employers”.

17. Many local authorities are equally concerned about the lack of regulation and training for personal
assistants. Some are putting in place some tools to manage and mitigate these risks. A framework for supporting
personal assistants working in adult social care has been published by the Department of Health in July 2011,
and this is a significant step forward. It now needs to be implemented.

Access to support planning

18. Our research for the NAO shows that effective support planning plays a key role in enabling recipients
of personal budgets to use their budget in a creative, tailored and personalised way, which seem to lead to
better outcomes. However, access to support planning is patchy. Many users of personal budgets interviewed
could not recall discussing their goals with anyone, and did not think they had a support plan. Some recipients
of direct payments who had not had access to support planning were not sure about what they could and could
not use their budget for, which made them concerned that they could inadvertently misuse their budget.
Reflecting this, many local authorities said they were still building their capacity for support planning. Our
perception is that the successful roll-out of personal budgets requires effective support planning.

19. This is potentially something that user-led organisations (ULOs)\textsuperscript{196} could help to provide, along with
information, advice and support to people considering taking up direct payments or in receipt of a personal
budget. We have seen examples of local authorities working jointly with ULOs to deliver services to disabled
people and carers, which appeared to work well. All those involved felt that the ULOs could provide services
to disabled people and carers that the local authorities were not able to provide. However, not all local
authorities have well-established ULOs which can take up this role, and some ULOs may need help and time
to build their infrastructure before they can play such a role.

Information, advice and support for users of personal budgets

20. Information, advice and support to manage and switch providers is crucial to ensure all users are able to
exercise choice and get the most out of their personal budget. However, it is not always available, or not
always of the right quality.

21. Awareness of the risks and responsibilities associated with becoming an employer are mixed among
users of direct payments. While they are usually aware of the need to have a contract in place, sort out taxes
and national insurance, some do not fully realise what they are getting into until things go wrong and they face
legal action. Better information at point of enrolment is crucial to enable users to decide which type of personal
budgets best works for them.

\textsuperscript{196} ULOs are local organisations that are run and controlled by disabled people.
22. The lack of support to manage providers is particularly an issue for those who use their direct payment to employ their own staff. They want support with employment law, their responsibilities as employers and training in how to effectively manage personal assistants. The experience described by participants in some local authorities shows that support could be improved, in particular with regard to the availability and consistency of advice.

23. Some users of personal budgets are reluctant to switch providers, often saying that they are willing to put up with inconveniences as they are uncertain whether they will be able to get better care from another provider, this is particularly the case for providers of personal care services. Making it easy for users to switch suppliers is important to enable them to get good quality of care and support.

24. Overall, supporting users and carers throughout their journey with the personal budget—and not just at the start—is important in mitigating the risks associated with personal budgets. Practical support or training on recruiting and managing a personal assistant would make it more attractive for people to use their budget to hire their own staff. Similarly, some of the negative impact of personal budgets (such as budget misuse and problems with personal assistants generating stress, upset and confusion for users) could be pre-empted or reduced with a more robust monitoring and review system.

25. Further developing information provision, advice, and guidance, including ways of collecting and disseminating users’ feedback, is also likely to have a positive impact: this could make users more confident about switching providers, and ultimately improve the quality of care received.

Claire Lambert
October 2011

Submission from Barchester Healthcare (SC 49)

Summary

Barchester Healthcare believes:

— That older people, particularly older people with dementia, suffer a reduced quality of life and a diminishment of life chances through unnecessary admissions to hospital.

— That older people do not wish to die in hospitals and that better and cheaper alternatives exist to enhance such deaths.

— That savings can be made in NHS budgets through tackling these issues, freeing up resources to be re-focused on outcome based reablement and preventative care.

1. Introduction: Barchester Healthcare

Barchester Healthcare is a major provider of social and health care in the UK with over 200 homes providing nursing care, residential care, “close care” (assisted living linked to residential schemes) and supported living services. We also support people with long term care needs in the community. We offer support predominantly to frail older people and people living with dementia but we also support people with learning disabilities, people with long term mental health issues and people with traumatic brain injuries. We provide intensive shorter term rehabilitation and reablement services, linked to outcome-based interventions. Of our 10,000 service users, approximately half are supported by either local authority or NHS funding, including many people with continuing care needs.

The origins of Barchester go back to 1992 when Dr Mike Parsons, unable to find suitable long term care accommodation for two relatives, started his own care home company. From then, to the present day, Dr Parsons has guided Barchester from a single home operator to the fourth largest provider in the country. So the story of Barchester is of a company that has been in the same ownership for many years and has invested most of its profits into the enhancement of the care for its residents. Our commitment to high quality care is reflected in ongoing independent enhancement, which records that 97% of the people Barchester supports view their home as “warm and friendly”; 96% say they both that they “feel safe and secure” and that they are “treated with dignity and respect”.

As a major provider of varied and multiple award winning care services with strong links to the NHS, Barchester Healthcare believes it is well placed to offer the Health Committee constructive comments from a provider perspective on social care. We make this submission in the broader context of the government’s commitment to innovation in care and support and greater integration between health and social care.

We are very proud of our positive working relationship with PCTs and health commissioners and our commitment to staff training. Over the last year our innovative work in these areas has been recognised through

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the 2010 National Employer Service Award, winning the Macro Apprentice Employer Of The Year. In addition to a number of awards for quality of care we also received the prestigious Pinder’s Healthcare Design award for 15 years of consistently high standards in healthcare design. Further, our employees (which includes 2,690 nurses), voted us one of The Sunday Times 25 Best Big Companies To Work For again this year. We remain the only care provider ever listed—and we have been there four times.

Barchester Healthcare is a member of ECCA (Dr Mike Parsons is Deputy Chair) and a member of the National Health Services Partners Network, committed to partnerships encompassing health commissioners, local authority commissioners, NHS providers and the independent sector based on localised support needs. As an independent provider we have built our reputation for excellence on offering high quality services, investing in innovative building design, staff recruitment and staff training.

We will begin our submission by briefly describing the problems faced by older people in hospitals, looking at recent audits of standards of care. We will go on to look at the issue of dying in hospitals. We will show that the NHS is not succeeding in dealing with the Nicholson challenge, and that there are better choices and possible savings arising out of more constructive utilisation of residential and nursing care.

2. **Older People and Hospitals**

In considering the current situation of social care it is important to consider the position of older people in hospitals. Recent discussions surrounding the health white paper *Equity and Excellence: Liberating the NHS* and the Dilnot Commission have meant a new honesty about the benefits of keeping older people out of hospitals. Lord Warner, the All Party Parliamentary Group on Dementia and the Alzheimer’s Society have all recently pointed out how much money this would save—and how much better it would be for older people, too. Research shows that people stay in hospital beds for eight days longer that they need to on average. Most of these days are associated with older people with dementia, costing the NHS around £300 million pounds a year according to the All Party Parliamentary Group. If we can use residential homes for older people with health problems and eliminate these same people being confined to hospital beds (because of problems that are often as much social as medical) we will dramatically improve their quality of life in homely environments designed for comfort, with an emphasis on good food, meaningful activities, dignity and choice.

Because care homes conform more to everyday domestic environments, they offer not only better quality of life but a greater degree of retention of skills and maintenance of independence. This is a much stronger basis for rehabilitative work. The NHS has recognised this implicitly, with a decline in geriatric and psycho-geriatric beds from 74,200 to 16,000 places over the last 20 years. However, there is still scope to achieve 2.7 million fewer hospital admissions among the over-65s each year (a 22% reduction overall) according to *The Case for Social Reform*, published by the University of Birmingham in 2010. It is also important to bear in mind that an average hospital bed costs £1,500 per week, whereas an average nursing care home bed costs 50% less at £698 weekly.

It is worth also bearing in mind that people can, and do, use nursing homes’ care and skills to aid speedy recovery and rehabilitation, with the aim of returning home. One the principles we have established in developing a reablement and outcome based focus with NHS foundation trusts and with PCT/LA commissioners is that people should return home where possible.

3. **Quality of Care in Hospitals**

In addition to a record of unnecessarily lengthy hospital stays, there is clear evidence that a number of older people in hospital are not being treated well. According to *12 hospital inspections for standards of care for older people*, published by CQC in May 2011 some very basic needs are not being met. Older people in hospital’s nutritional needs are not being assessed and monitored. Older people are not being given help to eat or being given enough to drink. According to the Health Service Ombudsman Report, *Care and Compassion?*, released in February of this year: "... accounts present a picture of NHS provision that is failing to meet even the most basic standards of care”. CQC picked up on these issues in its most recent report, released in October 2011, which noted that 20% of hospitals inspected were failing patients on dignity or nutrition to the extent that they were breaking the law, with a further 35% needing improvement in at least one of these areas.

This is not going unnoticed—there have been sustained campaigns in the media. It is reflected, too, in the fact that complaints about doctors and nurses have tripled in the last three years according to the Patients Association in September of this year.

4. **Dying in Hospital**

Such poor treatment in hospitals is reflected by the fact that many people do not want hospital-based care, particularly towards the end of their lives. Figures show that about 460,000 people die in England annually. Of this substantial number 89% would prefer to die at home or a hospice. In fact, hospital is the least preferred place to die. But in 2010, 63% of deaths occurred in hospitals and only 21% at home. There are financial as well as choice considerations, here, too: death in hospital costs about £6,231 per person, as contrasted with costs of £3,010 for dying at home with intensive support (*Nuffield Trust, 2010*). We also draw your attention to the work of Professor Malcolm Johnson, Department of Social and Policy Sciences, University of Bath and
his national study of “End of Life Care in Care Homes” (2009) which concludes that dying in a care home is likely to be a significantly better experience than the alternatives.

We draw your attention to this very moving film “Dementia and End of Life Care” by SCIE and Social Care TV which was filmed in Moreton Hill, a Barchester care home. It provides a great example of dignified end of life care in a care home.198

5. THE NICHOLSON CHALLENGE

All these factors need to be considered in the light of the financial position of the NHS generally. The health budget for 2010–11 was approximately 102.9 billion. The Nicholson challenge for planned savings requires that this figure should involve a saving of around £4 billion, and that this be a year on year saving until 2015. In fact, however, spending actually went up by about 3% on the previous year in real terms.

The truth is that there has been little evidence of the innovation that the Nicholson challenge requires. The National Audit Office says: “there has been no identifiable change in how PCTs have spent their budgets and no move towards providing cost effective care outside hospitals”. There is an over-provision of hospitals, with the Kings fund saying “up to 20 hospitals may have to close because they are not financially viable”. 55% of health managers surveyed said they did not believe they could deliver the required savings and only 27% said that they felt savings so far delivered were real (Association of Directors of Public Health survey).

We recognise one of the challenges in enabling change is that the majority of NHS commissioning budgets are tied into NHS contracts with little room to decommission specific services or commission new ones. At the same time the Continuing Healthcare budget is perceived as overspending as it is the only budget not tied into a large single Service Level Agreement and meets increasing individual need. This makes it extremely difficult for PCT commissioners to invest in new services, including outcome focused reablement and preventative services.

6. CONCLUSION

We can instance many examples of working collaboratively with the NHS. We have been able to facilitate early discharge into a quality environment and we have examples of our care homes actively preventing hospital admission. These examples arise where we have established a collaborative relationship directly with the local NHS provider organisation. A direct connection between operational staff and a clear outcome focus has been the key to success.

We understand that nursing homes cannot, and should not, provide highly technical and intensive care to people such as managing fractures, chronic obstructive pulmonary disease or intensive stroke care. However, in order to facilitate effective use of nursing home capacity, it is important to ensure that care pathways (and responsibility of assessment/discharge arrangements) are clearly agreed and that staff within both organisations have trust in each others skills and abilities.

Two areas where the leadership has been with the commissioning community rather than the NHS providers are Hampshire, where we have successfully developed a number of reablement beds with the County Council; and Norwich where, working with the PCT and a local primary care provider, we have established a “care closer to home” project. This offers five day admissions and instruction in tele-health care techniques linked to the GP practice. It has resulted in a 16% reduction in admissions for the practice. Examples of where we have, or are in the process of establishing pilots to reduce length of stay and facilitate discharge home or prevent Delayed Transfers of Care (DTC), include Lincolnshire, Blackpool, Kent, Humber and Cambridgeshire. We have also developed a range of innovative partnerships with mental health organisations reducing DTC, particularly for people with dementia and challenging behaviour. We have developed a Quality Account, piloted in some of our nursing homes, looking at a range of issues including admissions to hospital and we have introduced the Gold Standard Framework to many of our homes.

Barchester Healthcare would argue that these factors should not be considered in isolation. Given both that the quality of hospital care is often poor for older people and that many people would prefer not to die in a hospital there is clearly a strong case for making hospital admission the option of last resort, with residential care to be considered first. Since care homes provide a less institutional environment, they maintain skills and independence which hospital admissions frequently erode.

This case is strengthened both by the relatively low cost of residential and nursing care and by the need of the NHS to achieve substantial savings. In short, hospital care should be avoided for older people wherever possible. The position was summed up neatly by the All Party Parliamentary on dementia group this year: “The key aim of hospitals should be to keep people out of hospital…particularly…people with dementia, who are especially prone to the complaints of admission…infection, delirium, falls, etc.”

October 2011

Written evidence from the National Centre for Independent Living, Disability Alliance and Radar (SC 51)

About the National Centre for Independent Living

The National Centre for Independent Living (NCIL) is a national support, advice and consultancy organisation that aims to enable disabled people to be equal citizens with choice, control, rights and full economic, social and cultural lives.199

About Radar

The Royal Association for Disability Rights (Radar) is a pan-disability organisation led by people with lived experience of disability or health conditions. We work in broad partnerships to have the widest impact. Our vision is a just and equal society whose strength is human difference. Our mission is to enable individuals, networks and policy-makers to do things differently—and better.200

About the Disability Alliance

Disability Alliance was formed in 1974 to highlight and help eliminate the poverty experienced by disabled people in the UK. Disability Alliance is best known for publishing the “Disability Rights Handbook”—a comprehensive guide to support for disabled people.201

About the Joint Response and the Merger to Disability Rights UK

Radar, Disability Alliance and the National Centre for Independent Living are unifying to form a new robust, resilient and sustainable charity partnership, to represent and serve all disabled people in the UK. Disability Rights UK will be launched in the spring of 2012. Our organisations are led by disabled people. Between us we represent hundreds of individual disabled members, 500 local groups, national organisations and, through our members and activities, we support several million disabled people and their families, carers and advisors across the UK.

Through campaign work, policy engagement and focused lobbying we seek equality for disabled people, including through the promotion of independent living and tackling poverty. Our response has been developed in consultation with the members of our respective organisations. It is not exclusively focused on older people but rather draws on commonalities of social care experience by all people with support needs, including disabled people and those with progressive and/or fluctuating long-term conditions.

This response is supported by the Coalition on Charging. The Coalition is an alliance of national and local organisations campaigning against unfair charging for essential adult homecare services. Not all members may support all the points made and may have responded individually.202

For further background we would like to draw the Committee’s attention to our previous response to the Dilnot Commission’s Call for Evidence.203

Summary of Key Points:

— We welcome the Dilnot proposals for long-term social care funding as a fundamental stepping stone but equally call for action to address in the Government’s plans several concerns which would enable greater equity across sections of society.

— The Dilnot Commission is right to acknowledge that disabled people are more likely to live in poverty than other citizens. Any new funding system for care and support must not increase but mitigate the poverty experienced by disabled people. In particular homecare needs addressing through a taper for income-based charges which does not treat income immediately above income support levels as assessable at 100%.

— Social care needs to be recognised as a preventive service which reduces the impact on the NHS (budgets). Current charging levels undermine this 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).

— It should be made mandatory to introduce reablement and further preventive universal services more widely (alongside information and advice services) to benefit integration and productivity gains across social care and health.

199 www.ncil.org.uk
200 www.radar.org.uk
201 www.disabilityalliance.org
202 www.disabilityalliance.org/coalitiononcharging.htm
203 Response by DA, NCIL and RADAR to Call for Evidence on the Future Funding of Care and Support (Commission on Funding of Care and Support) http://www.ncil.org.uk/categoryid1.html
It is untenable that budget cuts are passed to local authorities with disabled people as a local minority missing out against more popular spending priorities. Conflicts of interests of local authorities interpreting national assessment criteria and underestimating need in favour of more popular spending priorities must be addressed. National assessment must lead to consistent provision whilst allowing locally responsive and community based solutions. Portability of assessments would be a significant stepping stone.

The insurance industry must provide equitable cover to everyone regardless of need.

The integration of social care and health services provides huge potential for savings and for improving the experience for disabled people (eg duplicate assessments). The Right to Control model should be followed for pilots.

The ILF (or similar national fund) could act as a national funding stream to share high care costs evenly between local areas—administered independently of local authorities. This would improve equity between individual councils in expenditure for disabled and older people. A continuum of support could start with Disability Living Allowance (DLA) and Attendance Allowance (AA) to cover for needs arising from disability or older age.

Innovation, integration and co-production with disabled and older people can prevent central budget cuts leading to cuts in frontline support. The pooling of personal budgets can foster collective experiences and enable personal budget holders to achieve greater economies of scale and access support which would have previously been inaccessible. Some peer support can be provided by disabled and older people themselves with positive knock-on effects on integrated care and support pathways. Cost-benefit analyses must be expanded and corresponding data shared in order to create a more level playing field between innovative micro providers and large contractors.

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

1. We welcome the Dilnot Commission’s proposals for long-term social care funding as a fundamental stepping stone but equally call for urgent action to address several concerns in the Government’s plans.

2. While the Commission was right to acknowledge that disabled people are more likely to live in poverty than other citizens,\(^{204}\) the proposals could increase rather than mitigate the poverty experienced by disabled and older people.

3. The means-test threshold from which people would be charged to pay for residential care would be raised from £23,250 to £100k. But homecare also needs addressing: currently, those with some income can be charged at 100% of assessable income immediately above income support level which leaves them with as little as £160.08 per week to live on (2011–12). Thus, most of the costs for the 35k cap for total lifetime contributions (£1.7 billion) would benefit relatively wealthier households. We therefore urge the Government to introduce a taper for income-based charges for homecare; the Commission itself suggested a taper of 65% of assessable income in line with the Universal Credit. In addition, there should be a raised means-test threshold for homecare while properties in which people live should continue to be disregarded.

4. It is false economy not to pool the risks of social care costs more widely and thereby prompt further investment into social care. From the point of view of the NHS, social care provides essential preventive care and support. Charging for social care does not only make many disabled and older people opt out of social care services, but their needs then deteriorate with substantially increased costs on the NHS (paid for by all).\(^{205}\) To an extent, this has been recognised by the universal provision of reablement services for up to six weeks, which are not charged for. We want such preventive, universal support introduced more widely, which would also benefit integration and achieve productivity gains across social care and health.

5. We welcome the proposal for a fairer, clearer and more transparent approach to national eligibility criteria which would go beyond the current Fair Access to Care Services (FACS) criteria as set out in the latest “Prioritising Needs” guidance. However, we expect that the continued interpretation of these criteria by local authorities would still undermine such commitment. For example, local authorities could understate the needs of someone born with a progressive condition so that this individual would just miss the threshold of 40 years of age up to which social care would be provided for free. The metering of accommodation (“hotel”) costs for residential care—proposed to be charged for between £7,000 and £10,000 per annum—is another example of this conflict of interests.

6. The Dilnot Commission suggests that more people should purchase insurance to provide cover against the high costs of long term care. However we fear that the private insurance industry would not deliver the required depth and breadth of coverage. Nor would it do this at an acceptable cost. Although insurance companies are covered by the provisions of the Equality Act 2010 meaning they must take all reasonable steps to ensure equal access to their products, an individual’s poorer health or chronic condition could mean an extra premium may be charged, cover declined or exclusion applied.

\(^{204}\) It is estimated that 30% of disabled people live in a household with an income of less than 60% of median national income, compared to around 16% of other citizens. Leonard Cheshire Disability, ‘Disability Poverty in the UK’, 2008.

7. We welcome that disability benefits such as Disability Living Allowance (DLA) and Attendance Allowance (AA) are not considered care and support funding in the Dilnot proposals as they are designed to help with higher costs of living which should not be confused with social care costs.

8. We unreservedly welcome the proposed introduction of a universal information and advice service for social care (and funding) which would enable everyone to form a view of current provision levels and plan ahead for themselves. Preferably, this service should be provided nationally as well as locally. The wider public is generally not aware of the growing burden on disabled and older people until they themselves or their families and friends are affected at some point in their lives. Then, there is often regret that the possibility of a social care need, which can be enormously costly for the individual, has not been faced up to before. This lack of awareness contributes to social care budgets not being ring-fenced but instead being used to plug other gaps in local spending priorities.

9. The ability of local authorities to decide how much funding people should receive for care and support is limited. Local authority budgets are too reliant on local political control and the local competition to reduce the level of council tax. It is rare that existing funding for care and support services is sustained against a freeze or cut in council tax. Without any safeguards such as a national framework or at the very least enhanced information and awareness levels and transparent and fully informed decision-making by local councillors, local authorities would (have to) continue cutting social care budgets.

The scale and implications of existing variation in access to and charges for social care in England

10. Reform of funding for care and support is a social and economic imperative. Unless there is equitable funding coupled with a genuine national framework, a postcode lottery—fermented by differing devolved policies on care service funding—will continue across the country with people being forced to use their life savings and to sell their home to pay for care bills. There are further knock-on effects on increased NHS costs due to unmet need at lower social care levels. This regressive system cannot go on. Even the additional funding that the Government has recently committed to social care has largely been used to achieve “efficiency savings” rather than sustain previous levels of (preventive) care and support. Further accelerating factors to the decline of social care are the demographic changes and the “care inflation” being higher than general rates.

11. There are currently 152 local variations for how social care is provided, including distinct local eligibility thresholds, numbers of and amounts spent on support hours for comparable needs and local charging regimes. Across the board thresholds have been increased, support hours reduced (often without re-assessment) and former caps for charging removed. This is because budget cuts are passed to local authorities with disabled people as a local minority missing out against more popular spending priorities.

12. Social care is only one area which affects disabled people with cuts to Employment Support Allowance (ESA) and Disability Living Allowance (DLA) also contributing to the cumulative impact for individuals; this race to the bottom is now exacerbated because the Government appears to have failed its own savings target on ESA by about £1 bILLion—not least due to failed Work Capability Assessments. For the new Personal Independence Payment (proposed to replace DLA) a further cut of 20% has already been factored in before any single assessment would have been carried out.

13. Yet, at the same time, with regards to social care, there is evidence that central budget cuts do not necessarily have to lead to cuts in frontline support if there is investment in innovation, integration and co-production with disabled and older people.206

14. We invite the Committee to note that not only the population will become increasingly older but also that there is a growing group of older people who look after their disabled relatives. As disabled people live longer, and family members of disabled people become older, they may not be able to provide the necessary physical support. However, they are still often expected to carry on their caring activities without any reassurance given by the state. This additional demand may be part-mitigated by people working longer (partly because of rising pension ages), which would lead to higher contributions made through a national fund, National Insurance or tax.

15. A centrally administered fund independent of councils such as the Independent Living Fund (ILF) could be introduced or revamped to meet the greatest needs (eg 24/7 care). This central fund could mitigate the burden on individual councils and disabled and older people, improve equity across local authority boundaries and enhance portability of assessments, care packages and outcomes. In effect, a transparent support continuum could be built which everyone would readily understand, starting with DLA paying for disability-related expenditure (and Attendance Allowance for needs arising from older age), social care and ILF covering the greatest needs.

16. A national framework for charging should be clear about what services would have to be provided free of charge such as reablement. Free respite care should not be limited to residential settings but extend to whatever setting the disabled or older person and their carer may choose. Re-labelling such preventive services to be able to charge for them should be ruled out. The ability for local authorities not to charge for social care should be maintained even if this now only concerns very few local authorities.

206 DEMOS, Coping with the Cuts. http://www.demos.co.uk/publications/copingwiththecuts
17. Such transparency with a national offer would take on board disabled and older people’s significant insights into how a condition or treatment can be managed as part of their lives. It would also activate support networks, peer support and help support to become geared around the individual rather than services. Disabled and older people would know in advance that some support will be available to them free of charge, and this would create an incentive to save and build up pensions earlier on in their lives.

The practical and policy implications of the Government’s commitment to promote personalisation of social care, including personal budgets and direct payments

18. Disabled people are protected by equality and human rights legislation to ensure that they have equal life chances to non-disabled people. Coming older generations will demand much greater levels and more innovative types of support. We strongly believe that disabled and older people should be able to live their lives as they want to instead of their lives being led by what care and support is available. A new social care funding system must support this new legal framework and ensure the delivery of equality and human rights for all disabled and older people.

19. The current social care (funding) system does not deliver equality for disabled and older people and is in desperate need of reform. Although disabled people have driven reforms (for example pioneering the Direct Payments approach), this has not gone far enough.

20. We welcome the take-up targets for both personal budgets and personal health budgets. However, in practice, personalisation is frequently undermined, because many local authorities use the personal budget process to reduce the allocated support hours and/or the cost for each support hour when compared to the former care package. At the same time, those more innovative types of support which disabled and older people want have often not been developed so that they can be left isolated in their homes (or expected to go to bed in late afternoon times). Then there are no clear and consistent arrangements about how the allocated resources could otherwise be spent to meet the agreed outcomes stated in the support plan.

21. NCIL has established a programme on user-driven commissioning which—as the first stepping stone—supports individual personal budget holders to come together in groups and pool their budgets to achieve economies of scale and/or access activities and support which would have previously been inaccessible to them. Such collective experiences of involvement have multiple knock-on effects such as enhanced peer support and improved quality and continuity of care pathways as well as health outcomes. NCIL approaches commissioners and user groups up and down the country to engage with this programme in order to create win-win solutions across social care and health.

The barriers faced by recipients of social care when they wish to relocate to another area, particularly with regard to the portability of assessments

22. Currently, the fear of the outcome and the wait and the possibility of losing support following the final re-assessment (as councils will interpret the criteria differently and meet different levels of care) inhibits many and older disabled people from moving. This denies education, employment, personal and other opportunities which are open to non-disabled people, not least support arrangements closer to where family and friends live.

23. A national assessment framework across local authorities would help to iron out some inconsistencies between areas but does not guarantee a seamless transition. Local authorities are already under a duty to cooperate but frequently pass the “burden” back and forth to the other council in order to cut back on or at least delay sometimes significant expenditure. At least, portable assessments would reassure the individual that his/her needs are equally valid in the new place. However, this still does not mitigate the fear that the new place may provide a much reduced care package.

24. This would be ensured by portability of care packages (and ultimately of care outcomes) which is addressed by Baroness Campbell of Surbiton’s Private Member Social Care and Portability Bill.

25. During the passage of both the Health and Social Care Act 2008 and the Personal Care at Home Act 2010, the previous government accepted that implementing portability would be cost neutral. With the portability of care packages, the cost for local authorities would be reduced as reassessments would become redundant or build on previous assessments. Only in a few instances would the move itself make a re-assessment necessary.

Economic regulation of the social care system including a proportionate failure regime that can mitigate against the failure of social care providers

26. We call for greater investment in the development of a more diversified social care market with more micro providers including some social enterprises run as user-led or mutuals or co-led (jointly with staff). This would reduce dependencies on large providers who largely institutionalise people and compete on price rather than quality. But it requires more willingness to extend the pooling of personal budgets and break down existing care and support pathways into smaller parcels which could then be commissioned separately for defined local areas. Alternatively, larger providers could be required to sub-contract discreet parts such as peer support to reduce premature referrals into acute care for example.
27. Some of the aspects of how a more level playing field between micro providers and user-led mutuals on the one hand and large block contractors could be achieved are addressed by Chris White’s Private Member’s Public Services (Social Enterprise and Social Value) Bill.

28. As the very minimum, the focus of social care providers on people who use their services must be strengthened. For example, routinely collected user-reported experience and outcome data would flag up early warning signs of economic and other failures in social care provision.

The practical and policy implications of the Government’s stated commitment to promote integration between health and social care services

29. Inefficiency and waste shape the current system of social care as in any system that is capacity-driven rather than demand-led. For instance, disabled people have to undergo many assessments—all pulling out the same information which could have been shared in a more efficient way with a minimum of distress and interruption to the individual. Reducing, even by a small percentage, the amount currently spent on assessment would deliver financial savings that could then be reinvested.

30. There are clear benefits to be gained from investing in care and support to help people stay at home who would otherwise be forced to go into acute hospital or residential care. For example, the ODI highlighted that support delivered to a person at home can prevent hospitalisation, the need for (expensive) residential care and deliver a better outcome:

“Adaptations give support to carers. By preventing back injuries and reducing stress, they lessen the costs to the health service. Carers in turn, if they are well supported, will save [councils] the costs of residential care... [and one]...social services authority, by spending £37,000 on equipment, was able to achieve savings of £4,900 per week in respect of residential care for ten people.”

31. Conversely, many disabled and older people can for weeks not be discharged from costly acute care simply because the NHS has not sustained sufficient community support or failed to develop joint arrangements with social care commissioners. Reablement has been introduced as a universal service to help people who have lost abilities following an illness, disability or accident for up to six weeks to become more independent at home following a period in NHS or residential care. Supporting independence will mean the person will not require, or will require a lower level of, care and support services.

32. There is still a dearth of corresponding cost-benefit analyses spanning investments and achieved outcomes across social care and health. This is because unit costs are often not identified and shared, eg to protect commercial confidence.

33. The Right to Control trailblazers launched in 2010 provide a useful model for piloting and evaluating improvements in integration and funding.

34. We strongly emphasise the need to give Centres for Independent Living (CILs) and User-Led Organisations (ULOs) and disability charities a central role in piloting and testing out integration. ULOs and CILs already facilitate and support people’s choices across health and social care. In addition, they can provide information on how the new care and support funding system works, its interaction with the NHS. When developing social care needs, there is nothing more effective than hearing from someone who has travelled a similar path in the past. ULOs and CILs can provide peer support in reablement services so that older and disabled people can contextualise a condition or a treatment within their own life domains, which would prevent falls by older people for example.

Conclusion

35. We are concerned that, in the current tough economic climate, radical reform of the funding system for social care and support will be sidelined or carried out in such a way that does not recognise the disadvantaged position of disabled people. We believe that this would be a missed opportunity. The NHS was born at a time of national resource shortages. In the current situation bold action should be taken to deliver a sustainable national framework and funding system for social care for the future of all.

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208 For further information please visit: http://www.odi.gov.uk/odi-projects/right-to-control-trailblazers.php
209 The Right to Control is a new legal right for disabled people. It gives disabled people more choice and control over the support they need to go about their daily lives. Disabled adults living in seven test areas will be able to combine the support they receive from six different funding sources and decide how best to spend the money to meet their needs.
Written evidence from Stannah Lifts Holdings Ltd (SC 52)

SUMMARY

— Housing adaptations can play a significant role in reducing the cost of social care by delaying or avoiding the need for residential social care.

— By preventing accidents and illness, home adaptations can reduce demand for costly social and medical care.

— Stannah is concerned that the removal of ring-fenced social care grants has led to funding being diverted from home adaptations. This will increase the long-term cost of social care.

RESPONSE

Housing adaptations can play a significant role in reducing the cost of social care by delaying or avoiding the need for residential social care

1.1 An ageing population and constrained social care budgets increase the necessity of finding alternatives to residential care where possible.

1.1.1 Housing adaptations which allow people to continue living in their own home are significantly cheaper than providing residential social care. The average cost of adapting a home to allow continued independent living is around £6,000. Postponing entry into residential care by just one year through adapting people’s homes saves £28,080 per person.210

By preventing accidents and illness occurring, home adaptations can reduce demand for costly social and medical care.

2.1 Home adaptations reduce costs to the NHS. The average cost to the state of a fractured hip is £28,665. This is 4.7 times the cost of a major housing adaptation and 100 times the cost of fitting hand and grab rails to prevent falls.211 One in three people over 65, and half of those aged over 85, will have a fall.212 Many of these are avoidable through housing adaptations.

2.2 Falls leading to hip fractures cost the NHS £726 million annually. Housing adaptations, including better lighting, can reduce the number of falls.213

2.3 Studies have shown that 51% of people in care homes have moved there after hospitalisation because a return to home is not practical. By making independent living practical, adaption can deliver significant savings and help maximise the social care budget.

Stannah is concerned that the removal of ring-fenced social care grants has led to funding being diverted from home adaptations. This will increase the long-term cost of social care

3.1 Stannah welcomed the announcement in the 2010 Spending Review that Disabled Facilities Grant (DFG) funding would rise with inflation up to 2014–15. The protection of this grant is crucial to the independence of older people in the UK. It helps reduce the dependence on residential care, and thus helps reduce the cost of social care.

3.2 However, while up until 2008–09 the Department for Communities and Local Government were required to meet 60% of anything local authorities spent, the grant is no longer ring-fenced and is allocated as part of the Single Capital Pot. This means that funding for a number of programmes is being pooled together and it is for local authorities to determine, against local priorities, how they best use these funds.

3.3 This means that the DFG funding is not being spent specifically on housing adaptations and is vulnerable when local authorities are under severe financial pressure. We know, for example, that adaptations on council houses using the Disabled Facilities Grant dropped 10,607 (26%) and work carried out on other homes fell 3,844 (15%) in 2010 in comparison to the previous year. This equates to a 22% overall drop in home adaptations and comes even before deeper cuts to local authority budgets take effect.214

3.4 Reductions in home adaptations increase the dependence on residential care and thus increase social care costs.

3. Stannah is concerned that cuts to local authority budgets will leave a £1 billion shortfall in social care funding by 2015, despite the additional funding announced in the Spending Review 2010. This will impact on the most vulnerable in our society.215

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October 2011

Written evidence from Savitri Hensman (SC 53)

1. SUMMARY
   - More funding is indeed needed for social care.
   - The Dilnot Commission proposals however are flawed in several ways.
   - It would be unhelpful to charge “hotel costs” for NHS continuing care.
   - The actual costs of care are often far higher than the notional costs (especially if the value of carers’ time is counted), and the costs of care would still be excessive for many people.
   - Adopting a “more consumerist” model of care may raise expectations, and lead to tension between users and carers on one hand and commissioners and providers on the other if these are not fulfilled.
   - Universal taxation principles would be more just in paying for care, as happens with other public services.
   - The principles of personalisation seem positive, but it needs to be adequately resourced and service users should not be pressured into receiving direct payments, though support should be available to those who want this. User-led organisations may have a valuable role.

2. BACKGROUND

2.0 I live and work in London. I have been a carer for about 23 years, supporting family members of various ages, including managing direct payments for a relative (now deceased). I am head of research and policy at a social enterprise, and much of my work focuses on health and social care policy and involvement at a local and national level, but I am writing in a personal capacity.

3. PRACTICAL AND POLICY IMPLICATIONS OF THE GOVERNMENT’S PLANS FOR FUNDING SOCIAL CARE AND DILNOT COMMISSION PROPOSALS

3.0 While successive governments have been reluctant to introduce any measures that will substantially increase public funding for social care, it is important to act boldly. The current situation is unsustainable.

3.1 The Dilnot Commission proposals seek to improve an unjust and inadequately resourced system. However some of the proposals are likely to cause injustice and practical problems.

3.2 Key flaws in the recommendations result from weaknesses in the body of the report, in particular:
   - the notion that “shared responsibility” between individuals or families and the state involves additional payments for public services, whereas social care users and carers have usually paid National Insurance and other tax, and often pay extra (in cash or kind) even for partly state-funded care, and contribute to society in other ways;
   - making calculations on notional costs of care, based on assessments by cash-strapped local authorities and sometimes inadequate even to meet basic human rights standards let alone ensure a reasonable quality of life for frail older and disabled people. The actual cost of support may be far higher;
   - failure to take account of the raised expectations that would result from a more “consumerist” model;
   - failure to recognise the seriousness of introducing payment for NHS-funded care that was hitherto free at the point of delivery;
   - focusing on housing as a resource of financial value, rather than somewhere to live and a place to which residents and families feel emotionally connected;
   - failure adequately to address health inequalities; the proposals are regressive, most benefiting those who are wealthier. But widespread poverty among many older and other disabled people and their families is a serious social problem.

3.3 If “hotel cost” charges were introduced for NHS continuing healthcare if delivered outside people’s homes, this could potentially open to the door to further charges for, say, longer hospital stays. This is problematic. It might also cause problems in hospital discharge. Suppose, say, that a man had a stroke, and after receiving acute care was invited to move to a rehabilitation unit funded through NHS continuing care, but knew he would have to pay “hotel costs” until, hopefully, he was well enough to return home, he might be hesitant, especially since he might also face additional expenses relating to his impairment (eg aids and adaptations).

3.4 Because of the enormous uncertainties about the overall costs of funding care (which fluctuate with demography, technology, social expectations, property values etc), insurance companies might well be reluctant to sell schemes that would not require very high premiums, which many people on low and middle incomes would find prohibitively expensive. In general, ensuring that adequate and affordable financial products were on offer would be difficult. It is likely that many individuals and families would hope that they would not need longer-term care (which in many cases would be correct), and those who did become disabled in later life might then have to pay the full costs.

3.5 While the Dilnot Commission proposals would generally reduce these (at least for people requiring residential care), many people would still have to sell their homes. It should also be noted that the cap applies to notional rather than real costs of care and does not take account of “hotel costs”, so in reality families might pay far more than £35,000 for care. If carers (other than spouses or civil partners) live with the person cared for, they might still be left homeless.

3.6 If paying substantially for care at the point of delivery, or taking out insurance or other costly financial products, users might well expect more hours of, and higher standards in, care than many currently receive, as well as a lower eligibility threshold. And carers who already put in many hours of care unpaid (both those on carers’ allowance and others who also carry out paid work or are pensioners) may feel that they should have far more time off than will in practice be available, if care is still heavily rationed. They may continue to feel “conned” if they do not get “value for money”. And confrontations with care managers would be likely to escalate.

3.7 The “potential future changes” include counting housing value as an asset in future financial assessments for home care and NHS continuing care users (some of whom live in their own homes). This would badly affect numerous service users with low cash savings but their own homes. To begin with, where would they live if they were forced to sell their homes to pay for care? This should be dropped.

3.8 Universal taxation principles, where the cost burden was proportional to earnings, other income or assets, would be more just, and easier to manage. So, for instance, people might pay more if earning well in their middle years, or if they received a substantial share income, towards their care in later life. The wealthy would still benefit from not being at risk of losing their houses, but the cost would be better adjusted to people’s ability to pay.

4. PERSONALISATION

4.1 The principle of tailoring care to individuals, and giving them more control is praiseworthy. However it is important that funding for care is transparent and at least sufficient to ensure a basic level of support, which some resource allocation systems do not achieve.

4.2 People should not be pressured to accept direct payments unless they wish to do so, especially since many have depression, dementia or other mental health problems. There should however be more support available from social services and user-led organisations to enable brokerage and other measures to give users more control, without necessarily giving them greater legal liability (eg as employers) and administrative burden.

October 2011

Written evidence from Mazars LLP, London (SC 54)

This submission is being made by Mazars LLP and has been prepared by Peter Gatenby who is the senior partner in the actuarial practice of Mazars LLP.


Mazars LLP welcomed the publication of the Dilnot Commission’s recommendations into the funding of care and support as a good first step to reaching a new national solution. In particular we see the proposal of a cap on the amount that people will have to personally contribute to their care as being an interesting concept which we believe would help stimulate the development of pre-funded insurance products and other funding vehicles should it be implemented.

Other recommendations made by the Commission such as changing the tax rules surrounding pension annuities would also help stimulate product development.

We believe that there is no single holistic solution to funding social care and that it is useful to look separately at short to medium and long term solutions.

Peter has a great deal of experience of long term care insurance, having been Chief Actuary of PPP lifetime care, a specialist long term care insurer which operated during the 1990s. Peter acted as a special adviser to the Health Select Committee during its long term care inquiry in the 1990s.
**Short to Medium Term**

In the short to medium term which covers those already needing care, those already retired but not yet needing care and those within five or 10 years of retirement a range of solutions must be developed to take into account the differing means of people in terms of both assets and income and ability to afford pre-funded insurance products.

On the whole, people in this category are asset rich (with the main asset being their home) and cash poor. As the insurance industry found during the 1990s although people could see the need and the benefit of purchasing pre-funded insurance for social care only a small minority could afford the premiums for such insurance.

It is certainly the case that if Government were to introduce a cap (such as the £35,000 recommended by Dilnot) then the cost of pre-funded insurance would be drastically reduced. Taking away the long tail risk would have a major effect on the cost. Studies conducted by Mazars show that the reduction in cost could reduce the premium rates of the most common products sold in the 1990s by two-thirds.

Even if a cap were introduced in the foreseeable future and insurance companies subsequently develop and launch products it will take some years for a significant number of people to be covered by insurance. In the USA long term care insurance has been in existence for 25+ years and to date only around six million people have purchased insurance.

For many people their house is their major asset and as such has been and will continue to be a major source of releasing funds to pay for care. Although there have been some innovative schemes in the past that link equity release to paying for care, we believe that the introduction of a cap will lead to providers developing a new range of innovative equity release mechanisms linked to social care.

The use of disability linked annuities was mentioned in the Dilnot Commission’s report. It certainly makes a lot of sense to allow an annuity to increase at the time that care is needed to help pay for care and it would be a relatively simple change to make to the tax rules surrounding pension annuities to allow such additional payments to be made. It is a travesty that this has not been a feature of the tax rules surrounding pensions.

The concept of the disability linked annuity is that at the time of purchasing the annuity from the pension pot available, a lower initial income is taken in return for a substantial increase in income should care ever be required in the future.

Although changing the rules to allow disability linked annuities is relatively simple it will only provide a viable solution for a relatively small number of people in the short to medium term as we are living in an age where most people are severely under-funded as far as pensions are concerned.

The use of a disability linked annuity alongside the cap would mean that the increase in income from the annuity would only need to take place for the period until the cap is reached, at which point the annuity would revert to the original level. Consequently the initial reduction in income would not need to be as great.

Without a mechanism such as the cap proposed by Dilnot, it would still be possible to develop and sell pre-funded insurance products, equity release linked to care and disability linked annuities, however the cost of these products would remain high and only relatively few people would be able to afford to use them as a viable solution.

If Government decides not to use a mechanism such as the cap then it is going to be very difficult to convince product providers to develop products as the market for those products would remain small. Therefore if Government does want to stimulate financial services product providers to develop products then some form of incentive or compulsion would be necessary.

**Longer Term**

As well as considering the funding of social care in the short to medium term it is imperative that Government grasps the nettle and considers a long term solution. There are two paths that we believe Government could take in this respect.

The only way to ensure that all people make adequate provision is to put in place some form of compulsory insurance scheme such as is currently the case in Germany. Although there have been teething problems with the German scheme and it has been revised since originally launched it will provide additional funding for care and ensure that large numbers of people do not end up having to spend all of their hard earned assets and savings in later life to pay for care.

Failing the introduction of a compulsory insurance scheme then the most logical home for care funding is as part of retirement provision. Pensions are all about making adequate provision for retirement and are generally designed to provide for a lump sum at or around the time of retirement followed by income for the rest of the retirees’ life. The lump sum at retirement has always seemed to be a bit of an enigma and an unnecessary part of a pension arrangement as what really matters to people when they retire is to have sufficient income in retirement to continue to enjoy a standard of living similar to that enjoyed pre-retirement.
If we consider income needs in retirement then they are likely to be greater in the years immediately following retirement followed by a period of fairly level income in real terms. We can then generalise the need for care by putting people into three groups:

1. Those who never need care.
2. Those who may have some mobility problems and find difficulty with some activities of daily life and need some assistance with general chores.
3. Those who need a substantial amount of care which could be given either in their own home, the home of a relative or in a paid for care home as a result of severe disability and are faced with an inability to perform activities of daily life. This stage may or may not follow a period as outlined in 2 above.

In each of the three cases outlined above income needs in retirement are quite different. In all cases there is a need for an income which at least rises in line with inflation for a number of years, perhaps with a slightly higher income in the early years after retirement.

For those in the second group once mobility becomes an issue then the rise in income may need to exceed inflationary increases so that there is more money available to pay for help with the chores.

For those in the third group there may be a period where the need for income starts increasing more rapidly eventually reaching a point where a substantial increase in income is required in order to pay for residential care or a substantial amount of care in the home.

What is clear is that not everyone’s pattern of income requirement in retirement is the same, however our current tax rules surrounding pensions and hence our current pension vehicles either provide for a level income or an income linked to inflation and not for the actual patterns of income needed for those who need care in later life.

It is possible to have flexible income if some of the more innovative income drawdown products are used but these are only aimed at and only appropriate for a minority of people.

If we had a blank sheet of paper and we were designing a pension (income in retirement) system from scratch then including provision for increases in pension to pay for care when required would most certainly be an important feature.

In order to ensure that people make adequate provision though their pension arrangements in the longer term we need to do more than just consider making changes to the tax rules surrounding disability annuities. We need to devise a system in which the pattern of pension income in retirement always includes an increase in income when care is required so that when younger people start funding for their retirement funding of social care is automatically included whatever pension vehicle they choose to use.

### Features of Social Care Funding Vehicles

Whatever mechanisms are developed in future to cover the short, medium and long term there are a number of features which always need to be kept in mind. In our view the most important of these features are as follows:

- **Sustainability**—the funding mechanisms themselves must be sustainable as must the tax rules and regulations surrounding them.
- **Sharing of risk**—there should be an appropriate sharing of risk between the individual, the product provider and the state.
- **Affordability**—there is little point designing funding vehicles and products that consumers cannot afford.
- **Direct linkage of the benefits from funding vehicles to social care.**
- **Serve the majority**—the funding mechanisms developed need to be designed to cater for the majority of people and not just a small minority.

We believe that the time has come for Government to provide some certainty around the funding of long term care and to put into place systems and legislation that will help people in the short term as well as providing a long term sustainable solution.

*October 2011*
Written evidence from Gateshead Council (SC 55)

INTRODUCTION

1. It is worth recalling at the outset, that the Law Commission’s report on Adult Social Care noted a “confusing patchwork of conflicting statutes enacted over a period of 60 years” when it reviewed legislation relating to residential care and community care, adult protection and carer support. Given the importance of user focused approaches and increasing moves towards personalisation, it is clear that a patchwork of legislation not easily understood by service users and carers is not consistent with a move towards greater personalisation, reablement and independence. Neither is it consistent with moves towards greater integration across health and social care and a focus on new models of delivery.

2. A key challenge for the forthcoming social care White Paper, therefore, will be to set the foundation stones for a more coherent and integrated approach, that establishes a clear sense of direction that is easily understood and, critically, is built upon a sense of fairness, enabling the needs of those who are most vulnerable to be met. This would provide the necessary platform to underpin legislative change to address the current “patchwork” of conflicting statutes.

3. This submission raises some key issues for consideration by the Select Committee in developing its recommendations to Government. In particular, a new social care offer is needed which sees investment in prevention, reablement and better information and advice, alongside joined up and consistent eligibility criteria for assessed needs.

A FOCUS ON PREVENTION, ADEQUATELY RESOURCED

4. The case for moving resources “upstream” is clear, both from the wellbeing perspective of the individual and the economic case for focusing more on preventing or delaying the need for social care interventions. The same rationale applies in the health care arena and the case for both are inextricably linked. As we move towards more integrated provision across health and social care, a consistent approach to moving resources upstream will be required. The forthcoming social care White Paper should look to facilitate this and ensure that resource pressures on the social care system arising from early and community based interventions are recognised and adequately provided for.

5. There will be a need to reflect the fact that those areas with traditionally high levels of hospital admissions will have increased social care costs as more peoples needs are met within community settings. In this way, the principle of moving resources upstream does not just apply within health and social care settings viewed in isolation, but between health and social care settings.

SHAPING THE MARKET

6. Building upon the community leadership role of local authorities, there is a need to facilitate their role in shaping the market so that a range of care and support services are available locally that meets the diverse needs of local communities.

FREEDOMS IN MEETING SOCIAL CARE NEEDS

7. Once eligible social care needs are identified, local authorities need sufficient freedoms to determine how they can best be met, whether those of users or their carers.

8. The Law Commission refers to government identifying minimum eligibility criteria nationally. This would facilitate the movement of packages of care across LA boundaries, providing a degree of stability for users and their carers. However, it will be important that these minimum levels are adequately resourced and that resources are also available to respond flexibly to local social care priorities. Funding levels will also need to have regard to different levels of need within different areas. This is in line with the findings of the Commission on Funding of Care and Support, chaired by Andrew Dilnot, which has recommended increased and sustainable funding for adult social care.

FACILITATING INDEPENDENCE

9. It is noted that the Dilnot Commission study “Public engagement: exploring care and support options” found that public awareness of what care and support is and how it is currently funded varied significantly. There was also confusion about the split between NHS and social care provision, particularly around long term conditions. As mentioned within the introduction, easy understanding by users and carers of the whole social care system will be important if we are to encourage and facilitate independence and progress the reablement agenda. It is timely, therefore, to review the two eligibility frameworks—fair access to care services and NHS continuing health care—to provide a greater degree of consistency and join-up across social care and the NHS. In addition, the legal challenge to Birmingham Council demonstrates a need to clarify the interface between the Disability Discrimination Act and the role of eligibility criteria.

10. A more joined up and consistent approach to care plans is also required. All people, irrespective of where they live, ought to have clear documentation setting out a summary of their eligible needs, expected care outcomes, their personal budget and financial contribution.
11. With regard to long term conditions (LTCs), work is currently underway in Gateshead to move towards single pathways of care for people with LTCs, encompassing health and social care. As part of an overview and scrutiny review of our Joint Strategic Needs Assessment currently being undertaken by our Healthier Communities OSC, a Kaizen event is taking place on long term conditions. The two day event will look at ways to join up approaches across the Council, PCT and GatNet (emerging Clinical Commissioning Group) and will use data from three GP practices as well as case studies of the experiences of people with LTCs. It will also have input from staff across these organisations and the VCS.

12. The targets set for the event are:
   - Increased systematic use of personalised care plans and emergency care plans;
   - Increased prevention activity;
   - Increased multi agency working/integrated care including health, social care and third sector;
   - Reduction in emergency hospital admissions/re-admissions;
   - Increased systematic use of self care management; and
   - Improved patient experience.

13. The Kaizen event also links with work to join up telehealth and telecare so that technology can be harnessed to help people to maintain their independence whilst also providing assurance to their carers and health and social care professionals. Clearly, there are costs associated with the roll-out of these technologies; opportunities should be provided for areas with high levels of need in particular to benefit from investment/innovations in these fields.

14. It will be important that the social care White Paper facilitates work of this nature to streamline and join up approaches locally for the benefit of people with LTCs.

15. More detail about the event and our work can be found through the following link.217

CAREERS NEEDS

16. The principle of portability of needs should apply to both the needs of users and their carers. Any minimum eligibility levels established by government for users need to be consistent with those set for carers and be adequately resourced.

17. The importance of informal care needs to be recognised, valued and supported, especially as traditional support networks are seen to be in decline. Relatives who wish to take on a caring role need to be adequately supported to do so.

ADULT PROTECTION

18. Finally, local authorities should have the lead co-ordination role in adult protection, building upon its community leadership role. Opportunities should be taken to streamline and further align existing arrangements to facilitate joint working across agencies.

CONCLUSION

19. The points raised above demonstrate that there is an important opportunity to reshape the social care landscape and how it interfaces with health care to support more integrated working and a more joined up approach across agencies. There are also opportunities to move resources upstream in order to focus on prevention and early intervention for the benefit of users and their carers so that people with social care needs can be supported to maintain their independence for as long as possible, enhancing their quality of life and overall wellbeing. This opportunity needs to be grasped.

October 2011

Written evidence from Action on Hearing Loss (SC 56)

1. Action on Hearing Loss is the new name for RNID. We’re the charity working for a world where hearing loss doesn’t limit or label people, where tinnitus is silenced—and where people value and look after their hearing.

SUMMARY

There are currently high levels of unmet need among people with hearing loss who either use or would benefit from care and support services. There are, in particular, the following issues:
   - Many local authorities do not adequately recognise or meet needs relating to communication. This means that people with hearing loss are not accessing the support that they are entitled to and which would improve their quality of life.

— People with hearing frequently do not benefit from joined-up health and social care. For instance, our survey of Action on Hearing Loss members found that when they were given their hearing aid, only 23% of respondents received information about any other equipment that might be useful to them.\(^{218}\)

— Information about social services is not reaching those people with hearing loss who would benefit from it.

— Many local authorities do not take account of hearing loss in their planning processes.

— Portability and ordinary residence rules make it difficult for people to move areas and for care home residents to move to more independent settings.

— Some guidance such as Think Local, Act Personal (this paper states that Individual Budgets would ideally be taken as a cash payment) recommend that direct payments should be the default option for individual budget recipients. However, many people would prefer to use council-commissioned services.

In order to address some of these concerns we are calling for the implementation of the Dilnot and Law Commission’s recommendations and, in particular, the following:

— The new statute to set a broad definition of outcomes for social care. We believe that economic wellbeing should be added to this list of outcomes.

— People who enter adulthood already having a care and support need to be immediately eligible for free state support to meet these needs.

— Service-users to be provided with a copy of their care and support plan, signed by the local authority, which specifies the amount of their personal budget and how this has been calculated.

— Eligibility criteria to be set on a national basis and the introduction of portability of assessments.

— The government to develop a major new information and advice strategy to help when care needs arise. This information should be fully accessible to all groups, including people with hearing loss.

— The continuation of universal disability benefits as well as the rebranding of Attendance Allowance to make its purpose clearer.

We are also calling for:

— Hearing loss to be put on the agenda of Joint Strategic Needs Assessments, Health and Wellbeing Board and joint health and wellbeing strategies to ensure that people with hearing loss benefit from joined-up health and social care.

— People to have a genuine choice as to whether they receive their individual budget as a direct payment (or whether they would prefer to access council-commissioned services). Where they do choose to receive a direct payment it is essential that they receive adequate support and accessible information, in their preferred format, to exercise choice.

— The Government reverses its decision that people in residential care will no longer be allowed to claim the Mobility Component of Disability Living Allowance.

**CAPTURING AND MEETING NEEDS RELATING TO HEARING LOSS**

2. Many local authorities do not adequately recognise or meet needs related to hearing loss. This means that people with hearing loss are not accessing the support that they are entitled to, and which would improve their quality of life. We are concerned that, under personalisation, some local authorities are using Resource Allocation Systems, in order to arrive at an individual budget, that do not fully take into account peoples’ communication needs. For instance, the individual budget allocated may not fully meet the cost of a British Sign Language interpreter for a service-user who is deaf. Similarly, we are concerned that local authorities are focusing their resources on meeting personal care needs to the exclusion of needs related to communication and information.

3. Similarly, councils may not take hearing loss into account when planning services and people may not receive inappropriate support; in some cases people with hearing loss may have no choice but to use generalist care or support services that are not adequate to meet their needs, for instance, a mainstream care home without the provision of adequate support with communication.

4. Therefore we strongly welcome the Law Commission’s recommendation that the new statute should set a broad definition of outcomes for social care, including emotional well-being, education, training and recreation, and contribution to society. This will work to ensure that social care services are well placed to contribute to a broad range of outcomes that typically improve people’s quality of life rather than being restricted to personal care needs. However, we believe that economic wellbeing should also be included as an outcome for social care. We know that economic wellbeing is an important determinant of people’s quality of life, and therefore this should be identified as an outcome towards which social care services should be directed.

\(^{218}\) Annual survey of members, RNID, 2008.
JOIN-UP BETWEEN HEALTH AND SOCIAL CARE

5. The potential for a more joined-up approach to health and social care represents an important opportunity. We find that people with hearing loss are not currently benefiting from joined-up health and social care. For instance, our survey of Action on Hearing Loss members found that when they were given their hearing aid, only 23% of respondents received information about any other equipment that might be useful to them. If audiology services and their social care counterparts were better integrated, they could deliver a more effective package to hard of hearing service-users to enable them to minimise the impact of their hearing loss. For instance, these integrated services could provide hearing aids along with the equipment that enables people to fully benefit from these.

INFORMATION

6. Recent developments in social care such as the implementation of personalisation mean that service-users will increasingly require good quality information in order to exercise choice. Similarly, as local authorities raise eligibility thresholds, there are increasing numbers of people who arrange and fund their own care and support; these people may not have any contact with local social services authorities and may be responsible for making complex decisions about their care and support on their own.

7. However, evidence shows that many councils are not providing this universal support and information that will enable people to make those informed choices around social care, to benefit from personalisation and, in some cases, prevent a moderate condition from becoming more severe. Recent research undertaken by the Association of Directors of Adult Social Care, the Social Care Institute for Excellence and the Joseph Rowntree Foundation found that, while there had been some improvement in the quality of information provided to people funding their own care and support, this remained variable.

8. For these reasons, we strongly support the Dilnot Commission’s recommendation that the government should develop a major new information and advice strategy to help when care needs arise. Information should be fully accessible to all groups. Appropriate communication support, such as a British Sign Language interpreter or a speech-to-text reporter, should be provided where spoken information is being communicated. In addition, any written information should be provided in British Sign Language clips and in plain English.

LOCAL AUTHORITIES’ PLANNING PROCESSES

9. Some local authorities meet the needs of people with hearing loss very effectively. However, we find that local authorities are not taking account of hearing loss in their planning processes. For instance, when we looked at a small sample of joint strategic needs assessments we found that they were not taking account of hearing loss. Therefore, these assessments should improve so that they capture the needs of all groups in order to improve commissioning.

10. For this reason, we are calling for hearing loss to be put on the agenda of Joint Strategic Need Assessments, Health and Wellbeing Boards, and joint health and wellbeing strategies to ensure that people with hearing loss benefit from joined-up health and social care.

PORTABILITY AND ORDINARY RESIDENCE RULES

11. Ordinary residence rules prevent people from moving from registered care into more independent living arrangements. These rules can cause difficulties where someone has moved from their “home” authority area to residential care in a different area. If they wish to move subsequently to a more independent setting in the same area as their residential care, the funding responsibility would then switch to that local authority area. Under the current rules this may cause difficulties—for instance, the “receiving” local authority may refuse to conduct an assessment on the basis that the service-user does not appear to be in need of community care services because their needs are already being met in the residential care setting.

12. For this reason, we strongly support the Law Commission’s recommendation that the statute should establish that when a service moves from one local authority to another, or has a clear intention to move, the receiving authority must carry out an assessment. If the new authority decides to give a significantly different support package it should be required to produce a clear written explanation to the service user.

13. A further difficulty arises from the fact that local authorities provide different levels of social care funding, depending on the eligibility criteria adopted. If someone plans to move area they cannot be certain that they would meet these criteria in in the new local authority area.

14. For this reason, we strongly support the Dilnot Commission’s recommendation that eligibility criteria should be set on a national basis and there should be portability of assessments.

219 Ibid.
15. As mentioned above, some Resource Allocation Systems, used by local authorities do not fully take into account communication needs. It is important that local authorities can work together with service-users to ensure that their personal budgets are sufficient to meet their needs. To achieve this, the process of allocating a budget should be as transparent as possible. For this reason we strongly support the Law Commission’s recommendation that service-users should be provided with a copy of their care and support plan, signed by the local authority, which specifies the amount of their personal budget and how this has been calculated.

16. There has been a growing tendency for government to present direct payments (rather than councils commissioning services or a third party managing the individual budget) as the preferred option. However, we strongly believe that people should have a choice as to how they receive their individual budget, people to have a genuine choice as to whether they receive their individual budget as a direct payment (or whether they would prefer to access council-commissioned services). Moreover, where they do choose to receive a direct payment it is essential that they receive adequate support and accessible information, in their preferred format, to exercise choice.

Continuation of Universal Disability Benefits

17. We strongly welcome the Dilnot Commission’s recommendation that universal benefits should be continued, as well as the rebranding of Attendance Allowance to make its purpose clearer.

18. AA plays an important role as an aid to independent living in that it enables the individual to exercise choice and control over their lives. In this way AA works to enable the government’s agenda around independence, choice and control.

19. Moreover, we believe that it is essential that the Government reverses its decision that people in residential care will no longer be allowed to claim the Mobility Component of Disability Living Allowance. This decision was based on an incorrect assumption that there is a duplication of funding. We know that this component enables people in residential care to stay in touch with families, friends and their local community. Removing it would reduce people’s participation in family, social and cultural life.

Conclusion

20. We welcome the opportunity to submit evidence to the Health Committee’s inquiry. We believe that it is essential that the Government takes action in order to address the level of unmet need in the social care system.

October 2011

Written evidence from Ideal Care Homes (SC 57)

SUMMARY OF RESPONSE

— Quality needs to play a more integral role in the Government’s plans for social care and should have had more prominence in the recommendations of both the Dilnot and Law Commission reports.

— Quality leads to improved outcomes, assisting the social care market in meeting the growing levels of unmet need and in finding efficiencies.

— Ideal Care Homes supports a nationally agreed rate for social care services with quality premiums attached.

— National standards and rates would help avoid the postcode lottery and variations between Local Authorities assisting movement within the social care system.

— A national, fair system of pricing will help mitigate failure in the market.

1. Introduction and Background

1.1 Ideal Care Homes is a residential and dementia care home operator. We currently operate 23 care homes in the North of England and the Midlands, with a further seven homes due to open in the upcoming months. Ideal Care Homes is a new name in the care sector but our reputation for delivering first class services is growing fast. Our concept is to offer the highest quality care at an affordable price for all and we have successfully abolished third party top up fees.

1.2 The Ideal Care Homes business model revolves around sustainability and quality of care. Our residential care homes are designed and developed from start to finish by the company to be fit-for-purpose and future-proof with every thought given to the well-being of the people who choose to live in them. One of the goals in founding Ideal Care Homes was to develop a model which could be adopted and maintained by other providers. Earlier this month, Sanctuary Care purchased one of Ideal Care Homes newly developed care homes in Sheffield. The home will continue to operate with the Ideal Care Home model but under the Sanctuary brand. This is the first significant step in cultivating the Ideal Care Home model in the social care market and could signify a major positive change in the way care homes are operated in the UK.
1.3 Despite the belief of many in the care sector, we are demonstrating on a daily basis that it is possible to maintain financial stability and return on investment without compromising good quality care and a stimulating environment.

2. 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

2.1 Ideal Care Homes are highly supportive of the principles behind the recommendations of both the Dilnot and Law Commissions’ reports. Creating a nationally fair system that puts the individual first is vital for reducing the growing levels of unmet needs that the social care system in England currently faces. However, an intrinsic part of ensuring the new system creates a sustainable and resilient framework for the future is improving the quality of services.

2.2 Quality of care is a fundamental issue in the social care sector, especially within the residential care market. It is unclear how the recommendations of the Dilnot Commission and Law Commission, as well as the Government’s own plans, would effectively deal with the increasing lack of quality provision.

2.3 Although the Dilnot Commission report does allude to the significance of quality services, and they believe their recommendations should have a positive impact on quality, they explicitly exclude giving recommendations on quality improvement, stating that, “It is not within our remit to explore these issues in detail as the Commission’s task is to advise on the funding of care, not its provision.” Instead they refer the issue to the Government White Paper on Adult Social Care.

2.4 We would argue that funding and quality should have a strong bearing upon one another. Funding that is responsive to quality should result in higher standards overall. At present quality is divergent across the country, with areas where services are better commissioned, receiving higher quality care than others where there are fewer funds available and commissioning is based on a “race to the bottom”. To respond to this national divergence in quality, Ideal Care Homes would be extremely supportive of a nationally agreed fee level. This could then be accompanied with a series of quality premiums attached to reflect quality in the market. Quality premiums should be grounded on a combination of physical and environmental factors as well as the qualifications of the provider and results of user experience.

2.5 Ideal Care Homes would be keen to see the role of the Care Quality Commission (CQC) maintained as a high level regulator of commissioning bodies with further clarity and prominence given to the regulatory role of local contracting bodies. This should incorporate recognition of their transactional role in promoting quality.

3. The scale and implications of existing variation in access to and charges for social care in England

3.1 A “postcode lottery” currently prevails in the adult social care market. Variations between Local Authorities (LAs) cause vast inequalities and unfairness in the system. These local disparities impact on the experience and expectations of users. Local residents in some LA boundaries receive minimal, if any, funding for certain needs/conditions, whereas their counterparts in other LAs receive higher levels of funding and far better service quality. There are examples of neighbouring authorities paying around £150 difference for the care of older people who have the same presenting level of needs. This cannot be right.

3.2 The 1993 changes made Local Authorities (LA) the gatekeepers for accessing residential provision when at that point the “fee” was effectively set at a national level. Since then the LA’s have made incremental decisions which have resulted in significant variations.

3.3 In order to reduce these variations in adult social care there must be a consistent national standard of quality of care to effectively remove this arbitrary postcode lottery. Nationalised standards would ensure that equivalent levels of funding are available for all service users who present with the same needs.

4. The practical and policy implications of the Government’s commitment to promote personalisation of social care, including personal budgets and direct payments

4.1 Ideal Care Homes is fully supportive of personal budgets and direct payments. However, in order to ensure that the resident’s best interests are taken into account, residential care must be considered as one of the available options. Despite the frequent perception of entering the residential care setting, this can often be a highly positive move for some service users.

4.2 The structures of these new funding mechanisms should not create an incentive to choose one type of service over another. The decision as to whether or not someone moves into residential care should purely be based on need, rather than financial calculations or a preconceived notion that service users will receive better care in their own home.

4.3 A resource allocation system (RAS) that links dynamically to the Charging for Residential Care Guide (CRAG) to permit individuals to access residential care settings outside of the NHS and Community Care Act could enhance the positivity and range of choice open to individuals. Such a system could give individuals the opportunity to waive the £14,000 disregard if they so choose, in effect widening the availability of care options.

221 Fairer Care Funding, Dilnot Commission, 2010, pp 50.
These same individuals could make the same choice when choosing to rent a flat so why should this be any different from a care bed, if the offer is there for them to choose either way?

4.4 To obtain a high quality of services, even once national structures for personal budgets are in place, contracting bodies, such as local authorities, must have more freedom in their approach to partnership arrangements with providers outside the public sector. New arrangements for how public money can be spent need to be created to place LAs on a more business like footing. They need to be capable of making the same decisions as any respectable business could, in order to both find efficiencies in staffing costs and ensure choice of quality services. Creativity is much more widespread within a business environment than in public sector provision at present. This is what enables the private sector to operate with much greater efficiency than the public sector. Innovative care and business structures within the private sector can often assist in raising standards. However, risk aversion holds back much of the creativity that no doubt exists in the public sector and thereby reduces choice.

5. The barriers faced by recipients of social care when they wish to relocate to another area, particularly with regard to the portability of assessments

5.1 This is not an issue that Ideal Care Homes has particularly encountered in regards to assessments. Nevertheless, a nationally agreed approach to funding would be extremely beneficial for circumventing this problem. Local Authorities have a tendency to attempt to obtain the lowest possible price ie paying the lower of their own price or the price of the host LA. A consistent national approach would prevent a variation in fee pressures determining the services recipients of social care are entitled to between LAs.

5.2 Even within LA services, at present the ability for individuals to move between service providers is often stifled by the safeguards used by Local Authorities with Social Services Responsibilities (LASSRs) to avoid movements to better offers within the care sector. Once again, the creation of nationally agreed fees and the introduction of personal budgets would allow for more fluidity internally in LAs as well as between LAs.

6. Economic regulation of the social care system including a proportionate failure regime that can mitigate against the failure of social care providers

6.1 Failure within the social care system is a product of the lack of consistent and fair pricing. Social care providers are forced into competitive situations where they must provide prices which are not sustainable. If providers are given a fair price for care, they should not fail.

6.2 To prevent this “race to the bottom”, creating a national framework, including standards and rates, would remove the current instability of the market. National rates would provide transparency for potential funders, providing security of investment in the sector. Sustainable development would thus result, and the greater market stability would assist in mitigating against the failure of social care providers.

October 2011

Written evidence from Care UK (SC 59)

1. INTRODUCTION

1.1 Care UK is a major provider of health and social care services. We provide care and support for older people and those with learning disabilities and mental health problems, as well as a range of healthcare services.

1.2 Working in close partnership with local authorities and primary care trusts, Care UK provides care and support for over 5,000 people in 90 nursing and care homes nationwide. We also provide 130,000 hours of support to people in their own homes every week.

2. SUMMARY AND RECOMMENDATIONS

2.1 Projected levels of local authority funding for service users in residential care risk undermining the development of the new care homes that are needed to meet future demand for social care, as well as undermining the viability of existing homes. If this happens it will have a socially divisive effect.

2.2 Britain’s care homes need private investment because public capital funding will not be forthcoming and demographic pressures signal greater demand for social care. Local commissioners must take these medium to long term factors into consideration.

2.3 Care UK agrees with the Dilnot Commission’s enthusiasm for integration of health and social care services and the need for a larger social care budget. The Social Care White Paper must develop these principles into viable proposals and a sustainable model.

2.4 To varying levels across the country, Care UK is seeing local authorities reduce funding not just for residential care but also for community care and home visits. Budget cuts for both these types of service mean service users are at risk of not receiving the support they need.
2.5 This is a false saving for local authorities because, if service users do not receive the level of support they need now, it will generate greater dependency on both health and social care services, adversely impact outcomes for people and eventually hasten a move for them into secondary care.

2.6 Current fiscal conditions and funding arrangements are pushing local authorities away from purchasing individualised services and back towards commoditised purchasing of care services. This will not advance the personalisation of care. Ultimately service users and their families should be choosing where to spend their budgets.

2.7 For genuinely personalised care, commissioners and providers need to work together to move away from bulk-buying and inflexible contracts. Those practices should be replaced by a holistic approach centered on the individual service user.

2.8 A more innovative and sophisticated commissioning model would enable providers to invest more in personalisation, implement improved case management and work with individuals to guide them through the care system.

2.9 Care UK also welcomes proportionate, consistent financial assessment applied evenly to all providers of social care.

2.10 An effective regulator of care provider quality is essential. It is equally essential that the public can gain independent information on care providers in an accessible format that helps guide an extremely important decision. Meaningful data is not currently available.

2.11 More needs still to be done to merge, or improve cooperation between, health services and local authorities, breaking down barriers to coordinating funding and creating integrated, more effective care pathways. Service users do not understand why these barriers persist.

3. DILNOT, LAW COMMISSION AND FUNDING SOCIAL CARE

3.1 In this section we describe how emerging trends in local authority funding impact on future provision of social care. We place our analysis within the general context of the Dilnot Commission’s key recommendations.

3.2 Projected levels of local authority funding for service users in residential care risk undermining the development of the new care homes that are needed to meet future demand for social care, as well as undermining the viability of existing homes. If this happens it will have a socially divisive effect.

3.3 Across the country Care UK is seeing local authorities move from commissioning block contracts to commissioning spot contracts. Councils are also referring fewer people to care homes because of a reduction in local authority budgets.

3.4 Moreover, in new care homes, levels of local authority funding per bed would be insufficient to meet the costs of developing them. Already, in some areas of the country, it is not economically viable to build a new care home with beds for publicly-funded service users.

3.5 This disincentivises the private investment that the social care sector needs to attract in order to build the volume of care homes required to meet the demand created by long term demographic change when publicly funded capital investment is also not an option.

3.6 At present, many providers run socially mixed care homes with places both for residents on local authority funded care packages and services users who are paying for their own care.

3.7 The levels of investment required to develop a new care home will mean only self-pay service users are able to afford these settings at a fee rate which enables the provider to repay its investors. For example, premiums being paid by privately funded residents can range from around 10% to in excess of 50% more than local authority funded residents. Fee rates for local authority funded care average around £500, while private residents pay £800.

3.8 This will have two effects. First, private care homes will become more socially exclusive as only self-pay service users will have the levels of funding to occupy a bed in a new setting. This will also restrict service user choice.

3.9 Secondly, with growing demand for social care in the medium to long term, local authorities will eventually face a shortage of beds. The disparity in funding present the risk of limiting places for local authority funded service users in residential care.

3.10 Britain’s care homes need private investment because public capital funding will not be forthcoming and demographic pressures signal greater demand for social care. Local authority budget settlements for social care, and the decisions of commissioners, must take these medium to long term factors into consideration.

3.11 For these reasons, Care UK agrees with the Dilnot Commission’s enthusiasm for integration of health and social care services and the need for a larger social care budget. The Social Care White Paper must develop these principles into viable proposals from which local government can devise a sustainable funding model. With its range of services across the health and social care, Care UK could provide better care at lower cost for the elderly in comparison to hospitals.
4. ACCESS, VARIATION AND TRENDS IN SOCIAL CARE PROVISION

4.1 In this section we discuss Care UK’s experience of variation in commissioning behaviour and service provision. We explore the effect this will have on quality outcomes for service users and the development of care pathways.

4.2 To varying levels across the country, Care UK is seeing local authorities reduce funding not just for residential care but also for community care and home visits. Budget cuts for both these types of service mean service users are at risk of not receiving the support they need.

4.3 This effectively restricts access and increases variation. Emerging gaps in support, particularly in domiciliary care, will cause service users’ conditions to deteriorate and, as a result, push them into greater dependency at a greater, longer term cost to the public purse. This may also occur because people could enter secondary care sooner than if a full care package was provided.

4.4 Residential care is more expensive than community care because it requires higher overheads. As local authorities tighten social care budgets, we are seeing commissioners refrain from directing people into residential care and instead construct a package of support to keep people in their own homes. This trend is consistent with policymakers’ preference for independent living rather than residential care.

4.5 There are, however, two problems with this approach. First, service users with complex needs, or conditions that make them potentially vulnerable, may receive more appropriate, personalised care within a residential setting than in their own homes. If commissioners steer people to supported living or home care who would be better cared for in residential care then it is likely to achieve lower outcomes for those service users.

4.6 Secondly, directing more service users into supported living or community care places additional burden on those services and funding for them. That funding, however, is not increasing. It is being spread more thinly, to reach a wider number of people.

4.7 As such, for example, people remaining in the community are receiving fewer home visits and less help with shopping, cleaning, dressing and meal preparation. Some will be able to continue this level of assistance with their own funding, others will not; leading to greater variation.

4.8 Care UK and our competitors are seeing a reduction in care packages. For example, the size of care package has in many cases reduced by about two hours a week. An average weekly package used to contain 10 hours of care; now the rate is more usually around 8, although the level of dependency is increasing.

4.9 At the same time, local authorities are only commissioning care for critical or substantial needs cases, which in themselves have increased in acuity—therefore staff are being asked to deal with higher levels of need with little or no extra remuneration.

4.10 Additionally, enhancement rates for sub hourly calls have in many cases been withdrawn following re-tendering of contracts, with little or no increase in “headline hourly rate” costs from most local authorities for the last three years. Care UK has seen a 5% reduction in revenue this financial year on tenders that have been re-awarded at reduced rates.

4.11 Indirect costs have also increased, along with the restrictions in provision and service user “churn”.

4.12 This is a false saving for local authorities because, if service users do not receive the level of support they need now, it will generate greater dependency on both health and social care services, adversely impact outcomes for people and eventually hasten a move into secondary care.

4.13 Local authorities need to be aware of the need to provide comprehensive domiciliary care packages, as preventative support at this stage of the care pathway can postpone service users moving into more intensive care.

5. PERSONALISATION IN SOCIAL CARE

5.1 In this section we suggest how local authorities, social care commissioners and providers could work together differently to develop greater personalisation of care services which will lead to better outcomes for service users.

5.2 Current fiscal conditions and funding arrangements are pushing local authorities away from purchasing individualised services and back towards commoditised purchasing of care services. This will not advance the personalisation of care. Ultimately service users and their families should be choosing where to spend their budgets.

5.3 Personalisation is often used interchangeably with personal (individual) budgets. This should not always be the case. Personalisation is also about commissioning and building services, for example residential care, supported living and domiciliary care, around individuals according to their needs at a point in time.

5.4 Personalisation is not happening evenly across user groups. People with complex needs, such as a mental health condition or learning disability, are seeing fewer advances in personalisation compared with people with disabilities or older people. This is because people with complex conditions often require greater support and
advocacy to help them make the choices about personalised care. Care UK seeks actively to work with service users, their advocates and relatives to find ways through these challenges.

5.5 Many commissioners of care services are finding the rollout of personalisation expensive. In Care UK’s experience, inflexible standard contracts exacerbate this problem. Some local authorities are proceeding with personalisation programmes more swiftly that others who are finding the transition difficult and expensive. This is fuelling the variation in service provision discussed in section 4, above.

5.6 Better commissioning guidelines and promotion of best practice would enable local councils to increase the rate of personalisation.

5.7 For genuinely personalised care, commissioners and providers need to work together to move away from bulk-buying and inflexible contracts. Those practices should be replaced by a holistic approach centered on the individual service user.

5.8 A more innovative and sophisticated commissioning model would enable providers to invest more in personalisation, implement improved case management and work with individuals to guide them through the care system. This would also transfer of risk from councils, with potential for cost savings, as well as enhance the service user’s experience.

6. Regulation and the Failure Regime

6.1 In this section we emphasise not only the importance of quality regulation for care providers but also the need to make this information accessible and meaningful for service users, their advocates and relatives. Care UK also welcomes proportionate, consistent financial assessment of all providers of social care.

6.2 Commissioners of care services must carefully and consistently consider the viability of the services they are purchasing, both in terms of user safety and financial sustainability. This will help prevent providers from offering very low cost services which then turn out to be unviable, leading to higher costs in the long run, disruption and poor care for service users.

6.3 But financial scrutiny of care providers must be applied consistently and transparently, using the same criteria for public, private and third sector providers. Only this fair and even approach to all types of provision can give service users reassurance of the financial health and stability of the care service they are using.

6.4 An effective regulator to measure the quality of care providers is essential. It is equally essential that the public can gain consistent, transparent and independent information and assurance on care providers in an accessible format that helps guide an extremely important decision for service users and their relatives.

6.5 Current plans are simplistic and do not to give the public meaningful data. Labeling a care home, for example, simply good or bad will not provide service users and their families with sufficient information to determine whether a provider is right for them. More detailed information—objective and measurable—is required to enable people to compare provision and make an informed decision that impacts their life considerably.

6.6 While a commercial operation could provide this data and guidance, Care UK believes it is preferable for service users and their relatives to have access to genuinely independent, regulated and comparable information that gives a holistic picture of each care provider. Ideally, an official, publicly funded body should provide this resource.

7. Promoting Integration between Health and Social Care Services

7.1 Care UK supports the principle of greater integration of health and social care services. This approach will help service users move along a pathway of care towards greater independence and dignity but with reassurance that they will receive the type of support they require should their condition periodically deteriorate.

7.2 In our experience, joint commissioning and transfer of budgets from health to social care still happens only infrequently. Moreover, the type of case management that enables integrated care pathways to function is also often absent.

7.3 We are not seeing many primary care trusts cooperating proactively with local authorities. This presents a barrier to integrated services. There is limited evidence to suggest this is changing, despite government statements urging the integration of health and social care. Examples such as the London Borough of Hammersmith and Fulham, where the council and primary care trust have merged chief executives and management, remain rare.

7.4 This impacts personalisation. Users and providers find it difficult to buy in services from across different health and social care funding streams. There is a lack of communication between health and social care professionals, including an absence of case managers working across both areas.

7.5 In residential settings it can be difficult for providers to access the right health services for their residents. There is a perception in the health service that care home staff should be dealing with the needs of their residents, and not using the services of GPs or district nurses. We emphasise that, while highly trained, care home nurses sometimes do not have specialist health skills for acute patients.
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7.6 We have also experienced cases of GPs charging an additional fee for providers to register care home residents. For example, GPs in Stanecroft (Surrey) charge a retainer fee for care homes that use their services. This is unfair and inequitable. Care home residents have the same rights to health care as everyone else and should be not be penalised.

7.7 Government still needs to do more to merge, or at least improve cooperation between, health services and local authorities, breaking down barriers to coordinating funding and creating better integrated, more effective care pathways. Service users do not understand why these barriers persist.

October 2011

Written evidence from the Care Quality Commission (SC 62)

SUMMARY

— Quality and safety are at the heart of the essential standards against which we regulate providers. Our annual report to Parliament, under the Health and Social Care Act 2008, includes a valuable insight into people’s access to care services, and the choice and control that they have when using services, as well as an overview of the shape of the market.
— CQC has demonstrated the substantial role it can play as part of a wider proportionate “failure regime” in the recent events with Southern Cross. Whilst economic regulation of the adult social care system is not within our remit, our commitment to partnership working with the sector, and efficient use of our regulatory model, is now supporting and protecting members of the public using the affected services during this period of transition within the system.
— Providers and commissioners must continue to work together in order to realise the ambitions of the people using services and policy makers with regards to better integrated, more personalised delivery of care and support. For CQC’s part, we are working to remove any unnecessary barriers to providers seeking to enter the market and those striving to deliver more innovative, flexible services.
— Although the proposed Excellence Award scheme will not be taken forward, CQC continues to work closely with the Department of Health and the adult social care sector to contribute to the wider work on quality improvement.

The Care Quality Commission (CQC) welcomes the opportunity to provide evidence to the Health Select Committee’s Inquiry on adult social care.

Our evidence is based on our regulatory activity and its findings. We have not commented in detail on the implications of changes to the funding system as we believe other stakeholders are better placed to do so. Generally, we welcome the proposals presented by the Commission on Funding of Care and Support as offering a fair and sustainable way forward.

1. Economic regulation, sustainability and safety of care

1.1 With regards to economic regulation and establishing a systematic “failure regime”, CQC has recently demonstrated how robust and effective the regulatory model can be with regards to mitigating against some of the risks associated with large scale failures of providers within the system. While economic regulation of the social care system is not part of our remit, in response to the recent situation with Southern Cross CQC had to consider the action it could take to meet the twin objectives of promoting continuity of care for those living in the homes and securing registration of alternative providers.

1.2 Southern Cross advised us and others of its intention to cease to be a provider of care services by 31 October 2011. Our role does not extend to commissioning services in response to failing providers. Our primary focus was to ensure that our regulatory model did not place any unnecessary barriers in the way of any providers who would be part of a “rescue” plan. Underpinning this was the fundamental principle that the continuity of care for those living in the homes should not be compromised.

1.3 The imperative was to work with key stakeholders to understand what role CQC could play in supporting the solution. From the onset, we worked closely with Southern Cross to offer guidance as to what we, as a regulator, would expect as it worked out ways to resolve the issue.

1.4 It was clear that the wholesale relocation of people living in the homes was not on the agenda and, therefore, we undertook a review of all potential implications arising from new providers taking over the homes. We had already undertaken a review of processes as part of our learning exercise around the transition programmes to date. We also created a virtual team to receive, assess, process and determine the applications. The key to the success of the process was to engage with incoming providers, give clarity about what was expected and required, ensuring we were sighted on these applications at all times, reviewing our processes and making changes as required.

1.5 The test of the plan was in delivery, and on 30 September 2011 we determined all applications which the new providers and Southern Cross requested. This allowed new providers to be registered in respect of the locations and for Southern Cross to apply to cancel registration against the same locations. Two further transfers
will occur in October before Southern Cross ceases to be a provider but, to date, the experience and process has been successful and positive.

1.6 In light of the recent turbulence within the system, CQC welcomes the recent launch by the Government of a discussion paper on the oversight of the social care market, which seeks views on the risks of financial failure of large providers which Southern Cross has brought to the attention of all. While formal economic regulation of the sector falls outside of CQC’s scope, we do gather some financial information on providers to monitor whether they have adequate resources to provide the quality of care required of them and have the power to impose conditions upon, and ultimately close down, providers who are at risk of being non compliant because of their financial situation. However, we do not have specific functions relating to ensuring service continuity should there be a provider failure.

1.7 Under the previous legislation, providers were required to produce, when requested by the regulator, their annual accounts, a bank reference, and information about the financial resources of the care home. The more general obligations contained in the new Regulation 13 do not, in CQC’s view, entitle it to perform such detailed scrutiny of a provider’s finances, and our regulatory methods therefore no longer include such specific analysis of a provider’s finances.

1.8 Care Quality Commission (Registration) Regulations 2009 place providers under an obligation to carry on any regulated activity for which they are registered in an efficient manner, with Regulation 13 specifically requiring that they ensure the “financial viability” of their enterprise. We have sometimes found that a service is able to prioritise good care even when it has encountered financial difficulties, and so we must not underestimate the complexity of these issues. Perhaps consideration should be given to the proportionality of future economic regulation of large scale corporate providers as compared to smaller providers who are less likely to operate on the stock market.

1.9 CQC’s primary focus is to ensure that people using regulated services are safe and experience the quality of care that they are entitled to expect under the Health and Social Care Act (2008). We will continue to work hard wherever we identify non compliance and breaches in regulations to avoid cancelling a registration where possible. We will coordinate our regulatory actions with commissioners to balance the risks to people using a service that is of inadequate quality against the risk of cancellation of that service and the need for commissioners to arrange alternative provision elsewhere. Whilst removing a provider from the market is the last resort, if the provider is in breach of the regulations we can, and will, take enforcement action where necessary and this may include cancellation.

1.10 In response to the Law Commission’s recommendations regarding the future of Adult Safeguarding Boards being put on a statutory footing, CQC is in discussions with the Department of Health on the regulators role in such essential partnership working arrangements in the future. We are keen to ensure our input and collaboration with the Boards remains positive, appropriate and as effective as possible. In parallel to discussing our role with the Department of Health to help inform any future changes to the legislation, we are continuing to revise our role in adult safeguarding, in light of the internal management review we have carried out following Winterbourne View. CQC is committed to learning the lessons and taking the necessary actions in light of those recent events.

2. The shape of the market and personalisation of adult social care

2.1 As outlined in our most recent State of Health Care and Adult Social Care in England report (2011), we have seen that the adult social care sector continues to change as new types of provision develop and expand to enable people to live at home longer. The number of residential care services fell by 10% between 2004 and 2010, while between 2005 and 2010 the number of domiciliary care agencies increased by over a third. The sector has seen expansion in some models of provision, such as Extra Care housing, and short-term nursing care in homes which appears to be replacing extended stays in hospital. Our report also contains information on the locations and different types of provision we have registered, including regional variations and the type of people who use the service, which may help to further inform your inquiry.

2.2 Given the rising demographic need, there are questions to be asked as to whether the market is developing at a sufficient rate to meet the aspirations of “A Vision for Adult Social Care” and for people who will need to use services in the future. This has also been explored in CQC’s market profile briefing which reported that, while there is some growth in the provision of services in the adult social care market, more will be needed to meet future care demands. Some of the people who we come into contact with do have personal budgets but the services they want to be able to use their money on are not readily available. This raises the issue of, not only people’s needs and aspirations remaining unsatisfied, but also the potential waste of public money.

2.3 The challenge is for providers and commissioners to work together to further develop the market and to anticipate future long-term care needs. In order to be sustainable, the system must be flexible to respond to increased demand as people live longer with more complex needs, higher expectations, and people explore ever more innovative ways of using their personal budgets to achieve better outcomes.

2.4 Self directed support via direct payments and personal budgets, as one vehicle for making care more person centred, can give many people greater independence and control over their lives, and have a positive impact on their well-being. CQC supports the greater deployment of personal budgets as a key driver to
creating a more diverse and flexible care market. However, we must recognise that, whilst the number of people able to exercise more choice over their care by using a direct payment or personal budget has continued to increase, many, especially older adults with complex needs or cognitive difficulties, still do not benefit from these options as equally as others. This may be because they lack the appropriate support to enable them to do so or because they do not favour them as a viable option. The funding reforms will need to support flexibility so that self directed support is not the only option available to people to ensure care and support is person centred. For those who do choose such an option, they must have easy access to support and advice to enable them to manage them confidently and with ease.

2.5 CQC has engaged with stakeholders to help us understand how the health and adult social care market is changing, what the implications are for our regulatory framework, and taken steps to identify and remove any unnecessary barriers that might stifle innovation in the market. For example:

— we have made the existing registration processes slicker and more streamlined, learning from the lessons emerging from the earliest phases of registration under the new legislation;
— we are developing our registration processes further to ensure they are “open” to any qualified provider delivering a registerable activity;
— we are developing a centralised registration team. We will continue to ensure the team is able to maintain up-to-date understanding and knowledge of developments and changes in the provider landscape, so as to react consistently where innovative and new services arise and providers seek advice on registration;
— we are making Improvements to information sharing and communication with providers and the public. For example, making the website more user friendly for the public to search for the full range of regulated services, and also to make it more useful for prospective providers to understand the scope and process of registration;
— we will continue to work in partnership with the Department of Health on the review of the regulations, including greater clarity on the registration of personal assistants;
— we will consider the role of HealthWatch England in identifying and sharing innovative practice examples; and
— we also plan some further work in collaboration with the Department of Health and providers to identify areas of duplication and excess bureaucracy in terms of regulation and oversight which may create unnecessary hurdles, especially to small micro providers. Where we identify duplication which can be removed we will endeavor to do so where possible.

2.6 CQC aims to ensure that our approach to fees does not distort the operation of the market and we will review our fees scheme to ensure that we can accommodate new models of service in a way that does not stifle innovation, yet ensures that we maintain the principle that fees are based on the cost of regulation and not the ability to pay. We are currently consulting on minor changes to our fees scheme including on the proposal to reduce the fee in the first level banding for providers of adult social care services without accommodation.

2.7 Shared Lives schemes are one example of an innovative and cost-effective form of care which CQC successfully and effectively regulates in a proportionate manner. We have been in correspondence with the Department of Health expressing our concerns regarding the Law Commission’s recommendation (75) for a regulation-making power to prescribe whether Shared Lives schemes should be considered to be residential or non-residential services. We understand the intention is to provide clarity about the legal status of Shared Lives schemes, and to allow sufficient flexibility to allow Shared Lives schemes to develop in the future. We are concerned, however, that this could have the converse effect. To introduce the option for some schemes to be defined as residential and become subject to residential care regulation we consider would be a retrograde step and contrary to the personalisation agenda. We understand the Department of Health are in active discussion with NAAPs about the best way forward.

2.8 The continued commitment to promote and drive integration between health and social care is so closely intertwined with shaping the market and developing more personalised services that the issues cannot easily be teased apart. CQC has reported on a number of occasions on how better joined up care can potentially better meet demand for services, deliver greater value for money, and most importantly meet individual’s needs in a more effective and efficient way. Both our earlier State of Care report and our final report on the assessment of councils’ performance in England demonstrated that some localities are able to demonstrate good partnership working between health and social care, enabling them to jointly tackle local priorities and improve the local populations’ health and wellbeing. CQC certainly hopes that the new mechanisms being put in place, including the sector-led improvement programme and the Health and Wellbeing Boards, will continue to drive forward the good practice where integration is already succeeding, and to share good practice and ideas where improvements are still required. The note of caution in this current financial climate, however, is that to ensure positive and effective integration remains sustainable, it must be ventured into with more good intentions than solely to reduce expenditure on service provision. Where the driving force is not primarily to improve the seamless delivery of services and to improve citizen’s experiences, the long term success of greater integration may be less stable.
2.9 For CQC’s part, regulation 24 on cooperating with other providers does provide an additional lever in the system to promote partnership working and to hold providers to account where they are not able to demonstrate compliance. A number of our forthcoming thematic reviews (a) health care in care homes and, b) end of life care) may yet yield more evidence on providers’ performance related to partnership working which we would be happy to share with you once completed, if of interest.

3. Variations in access and charges and better information for the public

3.1 We welcome both Commissions’ recommendations for a more objective eligibility framework and portable assessments which should go a long way towards addressing the inconsistencies and unfairness of the current system. Local authorities are best placed to understand, plan and prioritise for the needs of their local populations, but there does still seem to be a need for a national position on accessing the funding system which provides clarity and transparency to all people.

3.2 This is ever more important as we find ourselves in a turbulent climate, one of economic uncertainty and challenge. There is, and will continue to be, increasing demand on social care and support services, but the financial pressures within the system result in increasing numbers of people being excluded from publicly funded care, as local authorities tighten their eligibility criteria. This results in a number of consequences:

- people are faced with the choice of either having their care needs unmet or finding the funds to pay for themselves. This group of people can often face disadvantages in terms of choice and control over services;
- if less intensive needs are left unaddressed, people risk developing more complex needs and therefore may require more expensive and longer term packages of care;
- considerable pressures are placed on individuals, families and carers (financially, physically and emotionally)—the consequences of which can be damaging and distressing;
- as available funds within the health and social care system tightens, more costs will be shunted and there will be growing negative impacts for people in terms of what care they receive, where and when.

3.3 An estimated 45% of care home places in England are occupied by people who are self-funding rather than being paid for by the State. In addition, some people funded by local authorities have their care home fees “topped up” by relatives or other third parties, to bridge the gap between what their council will pay and what the care home charges. Across England, around a quarter of local authority care home placements may be co-funded in this way.

3.4 We know that for the majority people who receive publicly funded social care services their experience and quality of care is generally good. However, for those that fund their own care, navigating the system, finding the right information, in the right place at the right time to help them choose a service can be a very difficult process. And often people have to make significant decisions about their care and support at a time of intense pressure and stress during a crisis. Where people need care and support there should be a full discussion and assessment of their needs, regardless of their financial circumstances. If they are not eligible for state funded care they should be signposted to other information and support in a comprehensive way. This is even more crucial in those councils where only substantial or critical needs are eligible for funding.

3.5 We strongly support both Commission’s recommendations around better information and advice for the public, so that individuals can base their decisions on trustworthy, accurate information. CQC supports the recommendation for the Government to develop a “major new information and advice strategy” with a statutory duty on local authorities to “provide information, advice and assistance in their area and to stimulate and shape the market for services”. With the continued drive to shift responsibility and control for purchasing care to the individual through the use of personal budgets, there needs to be better processes and systems in place to support this, particularly around employment matters.

4. Recognising quality

4.1 As the Health Select Committee is aware, CQC is continuing to improve the way we publish information for the public about the services we regulate. Our new website has been launched this month, and testing has shown that it is a significant improvement in the way we display information. The new site was designed to provide the public with a clear and accessible way to check whether or not services are meeting each of the 16 essential standards of quality and safety and to enable them to search and compare services, based on the judgments we have made. We hope that people will find it much more helpful in making choices about care services. The new website also enables the public, and members of staff working in regulated services, to share their experiences with us, further enriching our Quality and Risk profiles on providers and feeding into our risk based approach to compliance monitoring.

4.2 As recognised by the Health Select Committee in its annual accountability hearing with CQC, our proposals to develop a voluntary excellence award for adult social care have been rejected by the sector. In response to the results of our consultation, Recognising Excellence in Adult Social Care, the Department of Health has now asked CQC not to proceed with the development and implementation of the proposed new award. The consultation did highlight a continuing enthusiasm in the sector for good quality care to be
recognised over and above compliance with essential standards of quality and safety. We will, therefore, be working closely with the Department of Health and other stakeholders, as part of the Caring for our Future reference group on Quality, to see how we might contribute to this wider work on quality improvement and enabling the public to make informed decisions about the services they wish to access.

4.3 We welcome the new responsibility for NICE in the Health and Social Care Bill to develop quality standards for social care (along side those that are being developed for health) and we are working with NICE to clarify the relationship between the quality standards and the essential standards of quality and safety against which providers of health and adult social care are regulated in order to comply with the Health and Social Care Act 2008.

5. Carers

5.1 As stated to our response to the Dilnot Commission, the current system can have a devastating impact on carers' ability to work, their own savings, pensions and health. Any reformed system must support and value carers, the costs of unpaid care should be visible and included in the analysis of the costs of care. No assumptions should be made about carers' willingness or ability to provide care in the future funding system. It is crucial that there is a rights-based approach to carers. The system needs to view them as having their own rights to a life, to work and to a social life. Although they are an incredibly important part of the care system, providing the equivalent of £87 billion of care, they are not simply providers of care. They need to be respected in this context but, fundamentally, these individuals have a right to their own life. Any system which simply views them solely as co-producers of care will be flawed. CQC welcomes proposals to give carers new legal rights to services and improved assessments and for carers to have better advice and support.

We hope the information and comments provided will inform your valuable inquiry into adult social care and the forthcoming White Paper. CQC is also responding to the Caring for our Future listening exercises and is actively participating in the quality and workforce work stream.

Supporting Evidence


Care Quality Commission, *The state of health care and adult social care in England, key themes and quality of services in 2009* (February 2010)


Care Quality Commission *Performance judgements for all adult social care services in England 2009–10* (November 2010).

Care Quality Commission *Response to the Commission on funding of care and support*, (January 2011).

Care Quality Commission *Response to the Law Commission consultation on adult social care*, (June2010).

*October 2011*

Written evidence from the Institute and Faculty of Actuaries (SC 63)

About the Institute and Faculty of Actuaries

The Institute and Faculty of Actuaries is the chartered professional body for actuaries in the United Kingdom. A rigorous examination system is supported by a programme of continuous professional development and a professional code of conduct supports high standards, reflecting the significant role of the Profession in society.

Actuaries’ training is founded on mathematical and statistical techniques used in insurance, pension fund management and investment and then builds the management skills associated with the application of these techniques. The training includes the derivation and application of “mortality tables” used to assess probabilities of death or survival. It also includes the financial mathematics of interest and risk associated with different investment vehicles—from simple deposits through to complex stock market derivatives.

Actuaries provide commercial, financial and prudential advice on the management of a business’ assets and liabilities, especially where long term management and planning are critical to the success of any business venture. A majority of actuaries work for insurance companies or pension funds—either as their direct employees or in firms which undertake work on a consultancy basis—but they also advise individuals and offer comment on social and public interest issues. Members of the profession have a statutory role in the supervision of pension funds and life insurance companies as well as a statutory role to provide actuarial opinions for managing agents at Lloyd’s.
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

1. The Institute and Faculty of Actuaries welcomed the publication of The Dilnot Commission’s recommendations into the funding of care and support, believing that their implementation could help individuals better prepare for retirement.

2. The Institute and Faculty of Actuaries looks to facilitate informed debate on relevant matters of public interest where our expertise can add value. The Dilnot Commission has recommended a cap on the amount people will have to personally contribute to their social care. In our view, the key here is clarity about what the State will contribute and what the individual is expected to contribute under a variety of personal circumstances (eg their income, their assets, the level and duration of care that they may need). If individuals are aware of what they will need to contribute then it could help them better prepare for their future. This greater certainty should also allow insurance companies to design more affordable and perhaps simpler products to help individuals with their financial planning for later life.

3. However, we suggest that it might be helpful to test the sustainability of the recommendations (eg the durability of the cap and the cost to tax payers) under a range of scenarios. Actuaries working in this area are likely to be engaged in further modelling/research in the coming months and years. For example they will be considering some of the following areas in light of the Dilnot Commission’s recommendations.

   — tax issues (eg tax treatment of disability-linked annuities);
   — asset decumulation (eg in conjunction with the means test);
   — care cost inflation and impact on projections;
   — conditions requiring care (eg dementia);
   — mortality/morbidity risk (eg insurance risk and longevity risk);
   — developing case studies, potentially using data from those in Local Authority care, looking at different scenarios and seeing how it changes under the current system and the proposed system under Dilnot;
   — international models especially with respect to non-compulsory schemes; and
   — assessment of the needs and options available to potential cohorts requiring care, eg working age (45 to 64), in retirement (65 to 84), in care (85+).

4. As a Profession we have published papers relating to the use of pensions wealth or housing wealth to fund care, both of which issues were highlighted in Dilnot’s recommendations. Set out below are some examples of such publications:

   — “Analysis of disability-linked annuities” (Rickayzen, 2007).
   — “A multi-state model of disability for the UK: implications for future need for long-term care for the elderly” (Rickayzen and Walsh, 2002).
   — “The role of private finance in paying for long-term care” (Mayhew, Karlsson, Rickayzen, 2010).
   — “Long-term care financing in 4 OECD countries: fiscal burden and distributive effects” (Karlsson, Mayhew and Rickayzen, 2007).
   — “Cost projections for long-term care in the United Kingdom” (Karlsson, Mayhew, Plub and Rickayzen, 2007).

5. The Actuarial Profession is currently undertaking a Thought Leadership Research Project on funding for long term care. The first phase of this is an in depth literature review of the international literature in the area of long-term care and the various means of funding it.

6. We would also encourage further research and the collection of meaningful data by Policy Makers in this area. We are ready to play our part in this work to help understand and manage the financial risks created by the demographic changes we expect in the future.

October 2011
Written evidence from Leon Smith, Chief Executive, Nightingale (SC 65)

Nightingale is a not-for-profit home for older members of the Jewish Community in Clapham, South London. It is one of the largest care homes in the UK, with almost 200 residents and provides residential, nursing, short stay and dementia care.

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

1. The social care funding system is on the brink of collapse. With estimates that over one million of us will live in care homes by 2051, something has to change: the current opaque, inequitable and incomprehensible funding system is no longer sustainable.

2. I have worked in the sector for almost forty years, working my way up to become Chief Executive at Nightingale, and I’ve seen many consecutive Governments issue reports with recommendations for the sector which have been quickly ignored, such as those put forward by Lord Sutherland during the previous government.

3. Andrew Dilnot’s proposals have the potential to finally create a more equitable and transparent social care funding system, so it is absolutely vital that they are implemented, or that elements of them are put in place.

4. At present, it seems that the biggest barrier to introducing these reforms is the estimated £2 billion cost to the treasury during difficult economic times. To believe those that say the government cannot afford to implement these reforms is to ignore basic laws of economics. Social care is expensive, but it pales in comparison to the cost of a long term stay in hospital.

5. For this reason it is vital that long term conditions, such as dementia, are indentified early and that individuals have adequate social care support, either in their own home or in a care home. Without this investment in social care, long term conditions easily turn into acute health needs—through a fall, or an accident—and people can end up being admitted to hospital. For this reason, the proposals laid out in the National Dementia Strategy published in 2009 must be implemented, with more investment in both early diagnosis and ongoing care.

6. Without effective social care funding, our aging population will put incredible strain on the NHS, ultimately costing the government many times the amount that the Dilnot recommendations will cost to implement.

7. That said, the details of Andrew Dilnot’s proposals have not won universal approval. Two points that should be noted are the following:

7.1 A failure to take family wealth into account could spur accusations that the tax payer is subsidising the inheritance of already-wealthy offspring who could have paid for their parents’ care. There is an argument to be made that wealthy individuals, or those with wealthy children, who could afford to cover the full costs of care, should not have their care costs capped.

7.2 There is still ambiguity on the part of local authorities around whether care providers can ask family members for third party contributions, with some local authorities allowing it and others not. It must be established that providers can ask for contributions from family members.

7.3 It is unclear how pensioners will meet the ongoing cost of accommodation, food and heating, the so called hotel costs, which in my experience are likely to be far higher than £10,000 per year. These additional costs mean that the proposed cap is, in reality, going to be far higher than the much publicised figure of £35,000.

8. However, it has been many years since we’ve been this close to a realistic solution, so politicians on both sides of the house have a responsibility to finally grasp the nettle and reform the system. It will be a tragedy if this chance is wasted, as it was following Lord Sutherland’s recommendations during the previous government.

THE SCALE AND IMPLICATIONS OF EXISTING VARIATION IN ACCESS TO AND CHARGES FOR SOCIAL CARE IN ENGLAND;

9. At present, the social care system is incredibly confusing for individuals and their families. I have personally come into contact with many people who had no idea how impenetrable the funding system was until they came to consider moving into a care home; indeed, this is the case for almost all new residents at Nightingale.

10. If people are to be able to plan adequately for their future care needs, it is vital that the system is the same across the country, and that it is clear and comprehensible to the public. Please find more information on this below.
Ev w150 Health Committee: Evidence

THE PRACTICAL AND POLICY IMPLICATIONS OF THE GOVERNMENT’S COMMITMENT TO PROMOTE PERSONALISATION OF SOCIAL CARE, INCLUDING PERSONAL BUDGETS AND DIRECT PAYMENTS

11. Any efforts to give residents of care homes more control over their lives must be welcomed. At Nightingale, we are pioneering the latest methods of person-centred care. Through a partnership with the University of Bradford’s Dementia Unit, we have developed a training programme that will see every single member of staff—not only carers, but managers, cleaners, chefs and so on—trained to provide individualised care that takes personal needs and preferences into account. This personalisation extends to every aspect of life at the home. It sounds basic, but Nightingale is unusual in that it gives residents the freedom to choose what time of day they get up, eat their meals and go to bed. This is absolutely vital to ensuring a decent quality of life for older people.

12. Therefore, the idea behind personal budgets and direct payments—that people will benefit from more control over the care and treatments they receive—is admirable. Many people will welcome the chance to have greater control. However, I do have some concerns.

13. It must be considered whether direct payments would work for everyone. Most of the residents at Nightingale have some form of dementia, and many would be completely unable to manage a budget for their own care. In these cases, responsibility would either have to be shifted onto a relative, or back into the hands of the local authority. This raises difficult questions about how you would decide who is permitted to receive direct payments and who is not, and at what stage in the progression of dementia this right is removed.

14. An associated concern is that this could make the process of collecting money even more complex for providers.

15. Perhaps more importantly, there is a risk that cuts to social care funding could make this a hollow gesture. Local authority payments already come nowhere near to meeting the true cost of care, which means we have to heavily subsidise our residents through our charitable fundraising, and it seems likely that further cuts are on the way. Therefore, even if residents are given control of these payments, they will discover that they are worth very little, and that the shortfall needs to be plugged with additional funding, whether that is from charitable fundraising or an increase in funding from the local authority.

16. On a related note, the government should consider ringfencing the funding provided to local authorities, to ensure a decent proportion is allocated for social care.

THE BARRIERS FACED BY RECIPIENTS OF SOCIAL CARE WHEN THEY WISH TO RELOCATE TO ANOTHER AREA, PARTICULARLY WITH REGARD TO THE PORTABILITY OF ASSESSMENTS

17. We are a home that cares for older members of the Jewish community, and we provide an environment that allows our residents to continue following the cultural and religious traditions they have held dear all their lives; familiar kosher food and celebration of religious holidays are incredibly important.

18. The unique quality of our home means that often, potential residents want to move to Nightingale from some considerable distance away. The complexity of relocation between London boroughs often makes this very difficult.

19. At present, different local authorities carry out different assessments, meaning an individual in one borough could be assessed as needing a care home, while an identical individual in a different borough could be told they must continue to manage.

20. If two individuals from different boroughs have been assessed as needing care and both local authorities are prepared to pay up to £500 per week, there are further differences that would have an impact on us as a care provider. One local authority may allow us to ask the family for third party contributions to the cost of care, which realistically is more like £1,000 per week than £500, while another local authority will not allow us to, meaning there are huge variations in the amount we receive for different residents. This can be extremely confusing for potential residents and their families.

21. That said, there are many people who understand the system very well, and spend a number of years trying to divest themselves of their assets so that, when the time comes for them to need care, their costs are covered. They are perfectly within their rights to do so, but effective means testing of family members and the right to ask for third party contributions would have a positive impact on the balance sheets of both care providers and local authorities.

22. These variations must be ironed out, both to avoid confusion for potential residents of care homes and to allow care providers to maximise their income.
ECONOMIC REGULATION OF THE SOCIAL CARE SYSTEM INCLUDING A PROPORTIONATE FAILURE REGIME THAT CAN MITIGATE AGAINST THE FAILURE OF SOCIAL CARE PROVIDERS

The difference between private and not-for-profit

23. The collapse of Southern Cross has demonstrated the inherent difficulties in running care homes for profit. With shareholders to pay, and private equity firms to satisfy, it is inevitable that corners will be cut, with balance sheets permanently at the top of managers’ minds.

24. Nightingale is a charity, and it is therefore very different from the private sector. Some 50 per cent of our residents are supported to varying degrees by local authorities, yet this income comes nowhere near the true cost of care, which is between £800 and £1100 per week depending on the level of care needed.

25. To bridge the funding gap, we fundraise extensively, and have built up a strong network of supporters. Many leave significant amounts to the home in their legacies. We also have 185 volunteers, who give up their time to run activities and befriend the residents. People run marathons for Nightingale, and organise all sorts of fundraising events. We have spent many years building excellent relationships with the community which we serve, ensuring that it takes as its responsibility the need to support us and to support older members of the community. This in turn means that, when people who have been involved with the home come to need care, they move into a place with which they and their families are already familiar.

26. This model allows us to guarantee a consistently high standard of care, and it demonstrates the stark difference between the private and non-profit making sectors. Our residents and their families know that a change in government policy, a fall in house prices or a struggling stock market will not result in standards slipping. Unfortunately, this model is a world away from much of the care sector, which is facing a looming catastrophe.

27. However, it’s an unfortunate fact that not all care homes can be built on the Nightingale model, and private care providers are here to stay. There are many profit making care homes that provide excellent care, but to ensure this is the case across the care sector it is absolutely essential that there is strong regulation. Private and charitable providers alike must be required to demonstrate that they are financially stable.

The CQC

28. At present, the Care Quality Commission is clearly not fulfilling its duty as a regulator to the standards we should expect. The Health Select Committee recently released an incredibly damning report, which seriously criticised the CQC’s ineffective management, distorted priorities and lack of control.

29. Most notably, the Health Select Committee said they were “extremely concerned” about the drastic drop in inspections carried out by the CQC in 2010–11 compared to the previous year, which “fell by an unacceptable 70%”, demonstrating a “failure” to meet the main statutory objective of the CQC. It specifically outlined the CQC’s failings in preventing the tragic abuse carried out at Winterbourne View.

30. This suggests that the CQC may be presenting an incomplete picture of social care in the UK. It recently released a report highlighting some shocking abuse and mistreatment in care homes in the UK, but given its inadequacy in inspecting regularly, things could be better than the report suggests, but they could also be far worse. Given the private sector’s propensity to cut costs wherever possible, which has an inescapable impact on care standards, this is extremely worrying.

31. Lack of confidence in the CQC’s information means that local authorities tend to carry out their own inspections, doubling the amount of work required by care homes.

32. This will continue to be a problem until the Government allocates adequate funding to the CQC.

THE PRACTICAL AND POLICY IMPLICATIONS OF THE GOVERNMENT’S STATED COMMITMENT TO PROMOTE INTEGRATION BETWEEN HEALTH AND SOCIAL CARE SERVICES

33. I have worked in the social care sector for many years, and the integration of health and social care has been talked about for as long as I can remember, with minimal results. The central problem is the fact that there is no agreed definition of the term integration, and no clear plan for what an integrated service would look like. The current funding system marks a clear split between health and social care.

34. On a local level, though, there are some excellent examples of the integration of health and social care. At the care home that I manage, we have our own GP practice and pharmacy, bringing elements of primary care into the social care context. We also have an audiology clinic which is a satellite from the local hospital as well as a dentist and physiotherapy clinic. There is a lot of scope for this kind of integration to happen in care homes around the country, though it needs some imagination on the part of providers of these services.

October 2011
Ev w152  Health Committee: Evidence

Written evidence from South East Strategic Leaders (SESLS), South East Councils Adult Social Care Members (SECASC) and South East England Councils (SEEC) (SC 67)

This submission draws on evidence and views from a number of South East councils and is a joint contribution from the above bodies. Some individual authorities will also be submitting evidence to the Committee.

**SUMMARY OF KEY POINTS**

— We welcome the Dilnot report on the funding of long-term care and its ambition to clarify how much individuals should pay towards their care by setting a cap on costs. We also support the proposals to raise the means testing threshold to £100,000 and extend the current deferred payment scheme so that it is a full universal offer across the country.

— It should be recognised, however, that the proposals will require very significant additional capacity for councils to respond to the increased demand for financial and care assessments. The state would, as a consequence of these proposals, have a relationship with a much higher number of individuals who need care than is currently the case.

— The demographic challenges of the South East, with an above-average ageing population, coupled with much higher numbers of self-funders than in other parts of the country, present a particularly stark funding problem which will require significant Government investment. SECASC estimates that councils could face a threefold increase in people needing support in future.

— We support the recommendations of the Law Commission’s report, particularly around the potential for sharing assessment arrangements with other agencies; the new duty to assess carers; strengthening safeguarding arrangements and the new lead role for councils in statutory multi-agency adult safeguarding boards; and a clearer definition of NHS continuing care.

— We support the principle of national eligibility and portability of assessments, but building on the Government’s localism agenda, individual councils should retain local discretion when commissioning services to meet the distinctive needs of their area.

— Transitional financial protection may be needed for councils who currently support people who may fall below new national eligibility criteria.

— We welcome the opportunities offered by the health reforms to improve integrated commissioning, working with partners and across the tiers of local government to maximise benefits for residents.

1. *The practical and policy implications of the Dilnot Commission proposals*

1.1 Broadly we welcome the report of the Dilnot Commission, and in particular the profile that it has given to the complex issue of funding long-term care, which needs urgent reform. Dilnot’s emphasis on the funding of care being a partnership between the individual and the state is a rational approach, and one that we support. Accordingly, we urge the Government to implement the changes based on the Dilnot proposal as quickly as possible.

1.2 The proposal for a cap on lifetime care costs payable by an individual, which is suggested might be around £35,000, introduces some clarity around the individual’s responsibility and would make it easier for people to plan for future care needs. It would also provide greater scope and incentive for the development of more suitable financial products to help people make provision for potential future care needs.

1.3 Local authorities would have a new responsibility under Dilnot’s proposals to assess and calculate when a person would become eligible for state funding, which would require significant additional resources in terms of assessment capacity, training and changes to IT systems. In effect, much higher numbers of people would enter the social care system as personal budget holders, albeit that they might be funding up to £35,000 of care themselves in the first instance. This has workforce implications, in that it would lead to a significant increase in the number of people requiring a care assessment.

1.4 Dilnot proposes that the means testing threshold for those entering residential care should be raised from £23,250 to £100,000 which we would support, along with the proposed extension of the current deferred payment scheme so that it is a full universal offer across the country. However, we are concerned that similar arrangements are not suggested for people who remain at home, who may have very high cost care packages, in particular, the high proportion of people falling into what is termed as “asset rich and cash poor”. There are also, again, implications for capacity, as authorities could see a huge demand in the number of people for whom it would become worthwhile to approach their local authority for help. This would increase the demand for detailed financial assessments, at a time when public sector workers are seeing the biggest job cuts ever. This transactional workload could be significantly reduced if the data sharing clauses in the current Welfare Reform Bill were approved to make financial assessments simpler for people and possibly undertaken electronically.

1.5 Dilnot’s report assumes that the funding required to implement the proposals will be passed by Central Government to local authorities, at an estimated cost of £1.7 billion in the first year, rising to £3.6 billion in the long term. However, work done in a number of South East authorities indicates that the costs are likely to be higher for the SE than the assumptions made in the report. This is largely linked to the high numbers of self-funders in the region. Although nationally, it is estimated that around 45% of people pay for their own
care, in many SE authorities the percentage is much higher. For example, Surrey—due to its relative wealth—estimates that closer to 80% of people fund their own care, whilst Hampshire estimates that around 60% are self-funders. With the additional pressures from self-funders, SECASC estimates that SE authorities could potentially be supporting three times the number of people they do now, before any demographic changes are taken into account. We would encourage the Select Committee to explore the possibility of a shift of 2–5% of NHS secondary care resources to fund key Dilnot proposals.

1.6 The variation in care costs across the country will also mean that an individual’s contribution of £35,000 will be spent more quickly in more expensive social care markets, such as the SE where labour and associated costs are higher. Dilnot’s proposals also do not appear to take into account the potential impact on the care market. If self-funders have a notional personal budget into which they contribute up to £35,000 of their own money, then they would quite rightly expect to be able to access the same rate for care as someone who was local authority-funded. This is likely to push up provider prices across the board, since it will be harder to justify charging self-funders a higher rate to subsidise local authority clients (as frequently happens at the moment).

1.7 The implementation of the key proposals contained in the Dilnot Commission Report and the Law Commission recommendations imply all social care staff, managers and lawyers in local government will need to be trained to understand and undertake new responsibilities. We would wish to see further information on the mechanisms for rolling this out nationally.

1.8 The public may form high expectations from the headline messages of the Dilnot Commission Report, specifically, matters such as the portability of assessment, national eligibility and capped contributions. Explaining the detailed implications to residents and managing expectations will place real pressures on local authorities at a time of unprecedented cuts in the public sector. For example, portability of assessment does not confer guaranteed replication of the same care package when a person moves from one local authority area to another.

2. Reform of social care law

2.1 The Law Commission’s recommendations have been welcomed by social care authorities, and will help greatly to make the legislative framework for adult social care clearer, more modern and more cohesive. Particular aspects of the recommendations we feel will be helpful include:

— The ability of a local authority to authorise others—such as a health professional—to undertake an assessment or aspects of an assessment on their behalf, subject to the local authority retaining overall control of the process (which would allow for joint health and social care assessments to be carried out by the same assessor, for example);

— The new duty to assess carers;

— Strengthening of safeguarding arrangements and a lead role for councils in statutory multi-agency adult safeguarding boards; and

— A clearer universal definition of NHS continuing health care.

2.2 We recognise that the Government has put in place secondary legislation to give effect to the operation of the Social Work Practice Programme pilot which enables the delegation of statutory duties. We would support the expansion of the programme ahead of the fundamental reform of adult social care law.

2.3 The Law Commission’s proposal—supported by Dilnot—to allow scope for introducing national eligibility criteria would aid transparency for service users. However SE authorities feel strongly that individual authorities need to retain responsibility at local level for how eligible needs are met, through locally commissioned services and local charging arrangements taking into account of the distinctive needs of each area and its social care market.

2.4 The proposal put forward by Dilnot, building on the Law Commission’s report, to base the national eligibility criteria at the substantial level may disadvantage the financial position of those local authorities which have continued to provide services to people who fulfil the moderate level of the current eligibility criteria. If eligibility was made uniform at substantial level and without local discretion, then a significant number of service users in some authorities would have to be reassessed and/or given transitional protection. We believe it is important that the local government funding formula is sensitive to this position, especially against the backdrop of current pressures to deliver Communities and Local Government savings over the next four or five years. In addition, councils have historically spent more on adult social care than is indicated by national government funding levels through subsidies from the council tax. This is a legitimate part of a set of local democratic decisions. All of these concerns would be reduced if the social care and welfare reforms and Dilnot Commission recommendations were supported by adequate funding for local government.

3. Variation in access to and charges for social care/barriers for social care users who wish to relocate

3.1 Dilnot recommends that assessments should be portable across local authority areas and that there should be a national assessment system. This would be welcomed as a mechanism for introducing greater certainty for service users who wish to relocate. However, local authorities would still need to retain discretion on the
services they provide to meet an individual’s assessed needs, since the range of services will differ in each area, as they are tailored to meet local needs. This implies that care packages would not be fully portable. In the same way and in line with localism, local authorities should retain responsibility for setting their own contributions (charging) policy.

3.2 The arrangements around Ordinary Residence need further consideration and can provide a barrier to people relocating, particularly where individuals (either as adults becoming more independent or children moving into adulthood) move from a residential setting to a deregistered independent living setting out of county. This can increase costs significantly for authorities who are net importers of clients as is the case for a number of authorities in the South East. We would want to see further clarification on this area especially as the Law Commission report did not make a recommendation on changing current Ordinary Residence rules.

4. Promoting personalisation

4.1 We welcome the opportunity offered by the Government’s agenda of expanding the options available to people who rely on adult social services to exercise greater choice and control. However, it is generally accepted that the existing legal framework is not in step with the fundamental building blocks of the personalisation agenda mainly because of the nature of statutory duties placed on local authorities. In brief, the existing rules constrain local authorities. Piecemeal steps such as the Secretary of State’s recent announcement to enable NHS Continuing Healthcare patients to access Personal Health Budgets, Right to Control and Social Work Practices pilot programmes are helpful but available to a limited number of local authorities. We support the drive to put in place further enabling instruments ahead of reform of adult social care law.

4.2 The Committee may wish to reflect on the balance of responsibility between the institutions of the state and the individual, as more people take on the responsibility for decisions about their care and support. There needs to be a clear statement of the limit of the local authority’s responsibility in this context. And if local authorities are to be held to account on corporate responsibilities grounds, then this need to be proportionate to reflect the new arrangements.

4.3 A key consideration in this respect that is worth exploring is who ultimately should bear the financial responsibility of accrued debt, when people choose to exercise choice and control through personal budgets. We would be pleased if this issue was clarified.

5. Economic regulation of the social care system

5.1 There is emerging evidence that some residential care homes for older people are struggling financially, yet the budgetary pressures have made it difficult for councils to re-consider an uplift to care home providers this year. In this situation we are not sure that economic regulation is the answer or even the way forward. In our opinion central government should look to develop initiatives that may help support the financial viability of the good quality, smaller care homes.

5.2 All industries experience cycles of change and continual business exit and entry, therefore the Government needs to be clear about the intended benefits of economic regulation. We do not believe that the Government’s discussion paper “Oversight of the Social Care Market” makes a compelling case for such regulation. Accordingly, the Government should ensure that a competitive market can thrive, and with allocation of sufficient grant to local authorities.

5.3 In light of the recent national media coverage of quality of care in homes we have greater concerns in relation to CQC regulation of standards and quality in the social care system than with economic regulation. We understand that although CQC plans to recruit more inspectors it is not on target to inspect all the registered providers in the region within the two year commitment timeframe.

6. Integration between health and social care

6.1 South East authorities are fully engaged in responding to the changes to the health system, working closely with our SHAs, PCT clusters and emerging clinical commissioning groups as well as working together across local government to learn from each other and promote best practice. Good progress is being made on developing the Health and Wellbeing Boards, due to the high numbers of Early Implementers in our area.

6.2 The majority of councils are actively planning and promoting integration between health and social care by focusing on two key areas: integrated provision/pathways, and integrated commissioning, the aim being to develop a system that can deal more effectively with the anticipated growth in the population and the health and social care pressures arising from it. Adopting this approach will help ensure we rely less on making changes to the formal organisational structures and concentrate more on the frontline managers and commissioning professionals who are taking many of the commissioning decisions in practice.

—— Integrated provision

There is a real energy and excitement within health and social care organisations in the region to deliver community health and social care integrated provision.
Integrated commissioning

Integrated commissioning not only brings together a more coordinated health and social care service but will help ensure patients/service users experience a single system. This will also improve organisational efficiency and effectiveness. However, existing integrated commissioning arrangements are too limited to deal with the scale of change. The need for developing clearer and simpler frameworks for the development of integrated commissioning, strengthening locality commissioning and developing new models of working are all key to promoting better integrated services. Effective cross-tier working will be crucial to improving health and wellbeing outcomes for local residents: for example, housing departments in our unitary and district/borough councils have much to contribute to the integrated commissioning equation, providing services that help to keep people safely at home and developing and providing supported accommodation.

There are a number of practical implications which need to be considered but should not be seen as barriers:

(i) Firstly, the need for mechanisms and willingness to share information across organisations, person held records and access to different systems and development of different data collection for separate performance frameworks.

(ii) Secondly, professional boundaries and not understanding different job roles; and developing working relationships across organisations and with GPs.

(iii) Thirdly, there are training implications in moving towards single assessment, since NHS care is not chargeable whereas social care is. Also delivering the personalisation agenda requires training for health staff to understand the way social care professionals undertake assessments and support planning.

(iv) Fourthly, there are also questions around management of staff and management structures across organisations, the geographical boundaries of local authority and NHS and co-location of staff across organisations.

(v) Finally, the development of a transparent risk sharing framework as a potential vehicle for managing shifting resources from secondary care to primary care as endorsed by the NHS Future Forum.

October 2011

Written evidence from the MS Society (SC 68)

About the MS and the MS Society

Multiple sclerosis (MS) is one of the most common disabling neurological conditions affecting young adults. Around 100,000 people in the UK have MS. For most people, MS is characterised by relapses followed by periods of remission while for others it follows a progressive pattern. The causes of MS are unknown, there is no cure and the treatments that are available are effective in only certain cases and for some of the time. MS symptoms include loss of mobility, pain, fatigue, visual impairment, numbness, loss of balance, depression and cognitive problems. MS can lead to severe and permanent disability.

The MS Society is the UK's largest charity for people living with MS, with approximately 40,000 members and 320 local branches. We provide grants to individuals, for home adaptations for example, and to public sector organisations, to co-fund specialist nursing and other posts. The MS Society's information and support services are highly regarded by the MS community, and continue to be recognised by prestigious national awards. The MS Society is Europe's largest charitable funder of research into MS.

This paper is based on the evidence we have gained from working directly with and for people with MS combined with the following research:

— The MS Society Big Care Survey 2009: In September 2009 we conducted an online survey to gather the views of 500 people affected by MS on the care and support system.

— Care and Support Services Consultation 2008: In 2008 we undertook a project to find out what people affected by MS wanted to see from a new system of social care. This included a representative survey of over 1000 people with MS, focus groups across the country and an open consultation through our MS Matters membership magazine.

— A constitution for social care: In 2009 we worked with Demos, Leonard Cheshire Disability and In Control to develop a constitution for social care. The project was carried out with 55 disabled people and their carers at workshop discussion groups across England, and with reference to our 2008 survey.

1. Summary

— The Law Commission and Dilnot Commission proposals are key to providing a transparent, sustainable and fair social care system.
Ev w156 Health Committee: Evidence

— A sustainable funding system in the long term must not be traded off against short term funding to address the current unmet need in the system.
— National eligibility criteria and portable assessment processes are essential, and a new system must cater for those with lower level needs.
— Personalisation is welcome, but personal budgets may not be the best way of achieving choice and control for everyone, and adequate investment is vital to ensure personalisation is not simply used as a cost-saving tool.
— Integration of health and social care services is vital to enable people with complex and long-term conditions like MS, to negotiate the complex web of care they face.
— Improved integration not only benefits individuals but health and social care budgets too.

2. 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

2.1 The MS Society welcomes the recommendations made by the Law Commission and the Dilnot Commission. We believe that these proposals offer a once-in-a-generation opportunity to transform our failing social care system into one that is fit for generations to come.

2.2 On the issue of funding, we particularly welcome the Dilnot Commission’s proposals for:
— A £35,000 cap on the amount of money people are expected to pay in their lifetime towards their social care.
— Free state support for those under the age of 40, with a cap on individual contributions rising at a rate of £10,000 a decade until retirement age.
— A rise in the means-tested threshold for residential care from £23,250 to £100,000.

2.3 At present people with MS can lose all of their savings and assets in paying for the care and support they rely on to go about their daily lives. One person with MS told us:

“While I was able to work I saved, and my husband was a policeman for 32 years which meant I received a lump sum when he died. But my care costs mean all our money will be gone in a few years—I can’t work out how not to use the capital. I’m worried sick about what is going to happen to me when I can’t pay for my care, and being stressed doesn’t help the MS. If you try and help yourself you seem to end up worse off.”

2.4 The proposals recognise that people who develop care and support needs have the right to save and accrue their own assets like any other member of society. Meanwhile, the cap would mean that no-one will spend more than 30% of their assets on care and support, as compared with the current system in which anyone with assets of more than £23,250 must pay the full cost of their care. The rise in the means-tested threshold for residential care addresses the current “cliff edge” that acts as a disincentive to save, and leads many of those who have to feel like they are being punished for doing so.

2.5 While we ultimately believe that care and support should be free at the point of need, we strongly support these reforms as a positive step forward in the current economic climate, and see them as a sustainable solution to the care funding crisis.

2.6 The proposals for wider reform of the current system are also welcome, and we strongly support recommendations for national eligibility criteria and portable assessments. These proposals have the potential to transform the lives of people with care and support needs, enabling them to access the same level of care, wherever they live in the country, and whatever their level of need.

3. Challenges

3.1 The proposals of the Law Commission and Dilnot Commission do, however, raise a number of challenges. Firstly, we have seen multiple attempts at reform over more than a decade, but most to little or no avail. Cross party talks are essential to form a consensus on this issue.

3.2 Secondly, the Dilnot Commission’s recommended £1.7 billion in additional public expenditure must not be seen as a stumbling block to reform. This funding is essential to creating a sustainable system for the future, and is less than 0.3% of overall public spending, and less than 7% of current government expenditure on social care and disability benefits.

3.3 It is also vital that the funding allocated for future reform is not balanced against the need for additional investment to address the current unmet need, or vice versa. The current care system is stretched to the limit and lacks the funding required to provide care and support to all of those who need it. Increasing numbers of local authorities are tightening eligibility criteria to provide support only to those with the most critical needs, as we demonstrate below. This is despite the Government’s assurance that extra money provided means that, “no council need reduce access to social care or fail to meet demographic pressures”. Increasingly strict criteria mean many people living with MS do not receive the care and support they need to conduct the most basic tasks essential to daily living. Qualifying for help is made even harder due to the fluctuating nature of the condition.
3.4 Lastly, both the Dilnot Commission and the Law Commission recommend a national eligibility threshold, which is vital to address the postcode lottery in charges and access to the current system. However, this threshold must take those with lower level needs into account, not just those deemed to be in substantial or critical need. Supporting people with lower level needs is vital to enabling them to stay healthy and independent for longer—as Andrew Dilnot highlighted.

4. Variation in access to and charges for social care, and problems with the portability of assessments

4.1 A current lack of national eligibility criteria means that people with care and support needs face a postcode lottery of support and care charges. For people living with MS, consistency of care across the county is a key priority: in MS Society research people with MS have been consistently virtually unanimous in saying that they should be entitled to the same level of services wherever they live, and should be able to move from one area to another without risking losing their care package, or facing high price hikes in charges.

4.2 The level of discretion awarded to local authorities to determine eligibility thresholds has allowed a tightening of criteria across the board, with over three quarters now restricting support to those with substantial or critical needs.222 For those living in areas such as Birmingham, where the threshold has been raised to critical, lack of access to support can make a vast difference to their quality of life. One MS Society member told us:

“I would like to live an independent life as much as I can but I do not seem to have the choice to be able to do so. I do not get enough help either financially or physically. I spend a lot of time in tears due to frustration in trying to dress myself and cook and wash my clothes.”

4.3 The experiences of someone with a similar level of need living in a different area can be very different. Derbyshire, for example, still provides support to those with moderate levels of need. Another MS Society member told us:

“I appreciate immensely the 4 hours weekly care offered to me. I consider this help to me and my family essential and it affords me some decency, self-respect and will to carry out my role as MS sufferer, mother of 3 school age children, wife and self employed partner in my husband’s business.”

4.4 For many people with care and support needs, moving to another area to receive a more generous care package is not a fair or realistic option. For some, the level of support they require is too great a barrier to consider such a move. While for others, the risk of losing social and support networks is too great.

4.5 Conversely, regional variations also mean that people with care needs who do wish to relocate risk losing the support they rely on, as this person with MS describes:

“Right now, I would be absolutely terrified to move to a different area, in case I can’t get the few hours of PA time that my local authority gives me now and that I had to fight so hard to get.”

4.6 The majority of respondents to our 2009 survey (71%) felt that the level of services (or amount of money to be given in a personal budget) according to a particular level of need should be set by an independent national body. Just 6% of people felt that local councils should continue to decide how much money should be spent on a person’s care, as they do currently.

4.7 The extent of variation in access to and charges for social care contributes to the confusion that surrounds the current system. In our 2008 research, 60% of respondents did not know which care services they would be entitled to should they need them, and 68% did not understand how much they would be required to pay for longer—as Andrew Dilnot highlighted. The King’s Fund, Key points, 27.09.11 http://www.kingsfund.org.uk/topics/social_care/

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5. The practical and policy implications of the Government’s commitment to promote personalisation of social care, including personal budgets and direct payments

5.1 Personalisation offers a real opportunity for people with MS to control the services they need to enable them to live the life of their choice. The additional flexibility provided by personalised services can be particularly beneficial for people living with complex and fluctuating conditions. For example:

“Flexibility is a fundamental part of care and carers need to be able to fit in with your needs. There have been many changes in my life since I was first diagnosed [with MS] but I have led a full and active life since getting a direct payment.”

5.2 Key benefits of a more personalised approach for people with a long-term or fluctuating condition like MS include the opportunity to be creative and take innovative approaches, alongside traditional care, and the ability to arrange more flexible and responsive services.

5.3 However, personal budgets may not always be the best way to achieve personalisation. Recent research conducted by Demos found that practitioners, encouraged by policy makers, sometimes see the two as interchangeable terms.223 But simply awarding a personal budget does not necessarily guarantee the most

222 The King’s Fund, Key points, 27.09.11 http://www.kingsfund.org.uk/topics/social_care/

223 Claudia Wood, Tailor Made: Personalisation must work for those who need it most, 19.10.2011 http://www.demos.co.uk/publications/tailormade
Ev w158  Health Committee: Evidence

personalised service for everyone. Personalisation is based on the concept of choice and control, and people with care and support needs should be given the right to choose whether or not a personal budget is the right option for them. Over emphasis on personal budgets risks failing to deliver personalised care for those with the most complex needs, who may benefit from alternative options.\textsuperscript{224}

5.4 Meanwhile, people who do receive a personal budget must be given adequate information and advice, advocacy and brokerage support to make the most of it. One MS Society member said:

“I had some support from a local advocacy service, which helped me with things like making sure I got the right amount of care and deciding how many carers I would need. I had to find out about employment laws myself, and I now do rotas, wages, tax, sick pay, holidays, contracts and dismissal—all that is involved with being an employer.”

5.5 Personalisation and personal budgets require adequate investment at the outset to ensure the best outcomes for those with care and support needs, and must not be seen simply in terms of cost-saving potential. A personal budget can only ensure choice and control if the budget offered is high enough to cover the care needs of the individual in question, as the following case study demonstrates:

Stuart is 40 and has primary progressive MS. He went into hospital following a relapse which resulted in him being unable to move.

Before Stuart went into hospital, his needs were assessed as critical, and he was receiving an intensive support package from the council worth £38,000, involving 56 hours of care per week (carers would get him up in the morning, prepare lunch and dinner and put him to bed in the evening). Stuart had been through 14 carers and before he had the relapse, was very excited about getting a personal budget as he wanted to get a PA—someone who would get to know him and support his individual care needs.

Stuart was assessed for a personal budget and an indicative amount of £11k was offered. This was appealed by his social worker on the grounds that this would not cover his care needs. The indicative budget was then further reduced to £10k, then £9k, then £7.5k. No explanation was offered other than that Hounslow Council had to make budget cuts. Stuart has likened the system to a fruit machine and says:

“You tell them [the local authority] what you need but there's no telling what you will get in the end, or for what reason”.

6. The practical and policy implications of the Government's stated commitment to promote integration between health and social care services

6.1 Integration of health and social care is vital for people with MS. “Webs of care” mapped by National Voices demonstrate that patients with long-term conditions like can be forced to negotiate complex webs of over twenty different professionals across numerous different departments, with little assistance to link them together, to secure the support they need.\textsuperscript{225} Many people with MS face a similarly complex web of access to a broad range of professionals, including MS nurses, occupational therapists, neuro-physiotherapists, social workers, neurologists, counsellors, GPs, and assessors for benefits and housing adaptations.

6.2 In our 2009 survey of people with MS, over 75% of respondents supported a joined-up service, but many people did not understand what this meant in reality. In focus groups they stressed the importance of a one-stop shop to provide information for all, and the benefit of having specialised support planners to help them negotiate the system. Integration must also extend beyond health and social care systems to include housing and benefits.

6.3 Improved integration not only benefits individuals, but health and social care systems too, preventing unnecessary hospital admissions and providing support to families that makes it easier for them to provide care in the home. “ENable” is a community neurological rehabilitation and enablement team set up jointly by Ealing Primary Care Trust and the London Borough of Ealing Social Services, and is an example of good practice on integration. The following case study illustrates how such an integrated service can provide a wide range of benefits.

Andrew has been living with MS for 25 years. He lives with his wife, his main carer. They were managing well until Andrew suffered a severe relapse resulting in decreased mobility, muscle weakness and fatigue. He was forced to rely on relatives to lift him from bed to chair or in changing position and began to suffer from depression and suicidal thoughts.

Andrew’s wife contacted the MS Nurse at the ENable team and she organised a joint visit with a Physiotherapist and Occupational Therapist to put together an action plan. The OT and PT looked into safe transfers and mobility at home and educated Andrew’s family in how to assist him, while the MS nurse liaised with the secondary care provider and GP to provide appropriate medical treatment at home.

\textsuperscript{224} Ibid p 17.

\textsuperscript{225} National Voices, webs of care, September 2011 http://www.nationalvoices.org.uk/integrated-care-1
The change of situation was communicated to the ENable social worker and a package of care was put in place. Additional carers supported Andrew and his wife with day to day basic needs, and a psychologist was provided to help Andrew with his depression.

Andrew’s condition has improved progressively. He did not need to be admitted to hospital, attends weekly gym classes and has ongoing rehabilitation to maintain the progress he has made. He and his wife are managing well again and no longer need additional help.

6.4 The MS Society hosted discussions between social care users, councillors, party members and Parliamentarians on integration between health and social care at political party conferences in 2010. Clear themes emerged from the discussions, highlighting some key barriers that must be overcome to ensure that integration can work:

— Healthcare is free at the point of need, while social care is means tested, and involves a contribution from all but the poorest users. Pooling budgets could help to go some way towards addressing the barriers that these fundamental differences present—some areas, such as Torbay, are already trialling this approach.

— Major cultural and structural differences exist between the health and social care systems. Innovations such as personal budgets and more patient-centred care and choice in the health system are bringing it closer to approach being championed by social care, and these should be further developed. Health and Wellbeing boards should also help to break down these barriers.

— Co-location of health and social care professionals, such as the “ENable” example, can be extremely helpful to reduce duplication of assessment, improve seamlessness and responsiveness of services and allow the sharing of expertise and information across health and social care boundaries. It also offers a “one-stop-shop” which is extremely welcome to patients and service users. However, examples of initiatives which co-locate health and social care continue to be limited—often due to barriers highlighted earlier. The current funding pressures in the social care system mean that the short-term start up costs of initiatives like the ENable centre are often prohibitive, despite evidence that such initiatives can offer long-term cost savings.

October 2011

Written evidence from McCarthy and Stone (SC 69)

SUMMARY

— McCarthy & Stone provides the majority of retirement and extra care schemes for purchase by older homeowners in the UK. The average age of its residents at the point of purchase is in the late 70s and all apartments include varying levels of care and support. To date, it has delivered 1,000 developments and more than 40,000 apartments throughout the UK.

— While residential and nursing care can be practical options for some in later life, most older people wish to continue to live in and own their own home even if they are widowed or need extra support. Few wish to be in rented accommodation at this stage of their lives with the financial risks that this involves.

— This submission outlines that neither the Dilnot Commission’s Report nor the Government has seriously considered the potential of specialist housing for older people to reduce the pressure on adult social care budgets and limit the need for older people to move into residential care. As such, this note calls for greater recognition to be given to this form of housing as part of the adult social care debate. Three key policy suggestions are made.

— This note also highlights specific points regarding the impact of direct payments and the role of extra care housing on assisting older people.

INTRODUCTION—WHAT IS SPECIALIST HOUSING FOR OLDER PEOPLE?

1. Specialist housing for older people includes retirement apartments (similar to Category II Sheltered Housing) and extra care schemes. It enables older people to maintain home ownership while having access to varying levels of care and support. Each apartment within a scheme has its own front door, a residents’ lounge, communal laundry, lifts, a House Manager and camera entry systems—they are designed to promote independent living in a secure environment and offer an ability to meet and socialise and possibly the preparation of meals and a dining room.

2. McCarthy & Stone’s three development types are:

   (a) Retirement Living (since 1977)—Similar to traditional “Category 2” type sheltered housing, but to Lifetime Homes Standards. It includes a House Manager, lounge, communal laundry, guest suite and lifts to all floors. Residents have active, independent lifestyles in a safe but private environment. The average age at purchase is in the late 70s.
(b) *Extra Care* (since 2000)—McCarthy & Stone has 42 extra care schemes for purchase, either open or under construction, making it one of the largest extra care providers in the UK. These dwellings are as above but are designed to full wheelchair housing standards and widths, have more services such as 24 hour staffing, a restaurant and one hour per week of domestic assistance, with additional domestic and care packages available. The average age at purchase is approximately 83.

(c) *Tailored Care Living* (new)—McCarthy & Stone’s Tailored Care Living first scheme at Littlehampton, West Sussex, will accept its first residents in Autumn 2011. It is similar to the above, but with assessment of care needs/packages on entering, with assisted bathing, treatment rooms, spa and hairdressing facilities. It is a direct alternative to traditional residential care but with home ownership retained. Likely customers will be those aged 80 plus, and will be frailer and with specific care needs at the point of entry.

3. Ownership for each of these schemes is generally self funding through the release of the £980 billion that older people hold in housing equity. There is no reliance on state funding. Paying for adult social care can therefore be paid in part by the release of housing equity and funded through an agreed service charge that covers care and maintenance costs.

4. However, although the number of people aged over 65 will grow from 10 million to 16.7 million by 2035, the UK has built just 105,000 specialist retirement homes for ownership, significantly less than other developed countries. Half of new household growth by 2026 will be by those aged over 65. Given the benefits noted below, particularly in reducing adult social care bills, and the growing need, Government must act now to help increase the availability of specialist housing for older people.

**HOW SPECIALIST HOUSING REDUCES THE PRESSURE ON SOCIAL CARE FUNDING**

5. Specialist housing for older people delays and in many cases prevents older people from moving into residential or nursing care. This form of housing offers degrees of care and support provided by qualified staff and is designed specifically with the needs of older people in mind. As a result, there is a real potential to divert people away from residential and nursing care. For each year a resident postpones moving into care, the states saves on average £28,080.

6. The extra care and tailored care living developments promote independent living but have the advantage that additional care and support can be provided seamlessly as needed. All of these developments built by McCarthy & Stone since September 2009 are managed by a Domiciliary Care Agency registered with the Care Quality Commission. The residents can therefore be assured that high quality personal care can be tailored to the residents’ needs. Also, the care packages provided are completely flexible, allowing care from as little as 15 minutes. This means that the packages can be tailored and adjusted to meet the fluctuating needs of the residents, increasing after bouts of illness, and falling away after a period of convalescence. By having this care facility available, residents are able to shorten their hospital stays and return to their homes professionally cared for by people they know.

7. In many instances, older people are equity rich but cash poor. In such cases, rather than rely on the care services provided by Local Authority nominated Care Agencies they could, if direct payments were the norm, use this money to engage the in-house care team at the extra care developments where they live. McCarthy & Stone therefore supports the increase use of direct payments.

8. Extra care housing allows couples, where one is in need of substantial care and support, to continue to live together, confident that the care needs of the frailer partner can be supported on site by the qualified care team. Moreover, the care team also provide care and support and respite care for the caring partner, which can also enhance the quality of their lives. It is often impossible for such couples to continue to live together once the frailer person is in need of several hours of personal care a day. A family home would need major alterations to the bathroom, a stair lift and other adaptations if the couple were to remain living there. All of these adaptations are already provided for in the purpose built extra care developments.

9. As such, this form of housing needs to be considered as part of the range of measures to tackle the funding crisis facing adult social care. On page 61, the Dilnot Commission’s Report provides a very limited reference to the fact that this form of housing could be one answer to the challenge of providing care for the elderly. However, given its potential, it has not yet been given the policy recognition it requires.

10. Recent research by Professor Michael Ball at the University of Reading highlighted the key benefits of this form of housing and noted why older people wish to live there. Professor Ball stated that because of its substantial benefits, more should be done to increase its supply. His report supported many of the findings

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226 All Party Parliamentary Group on Housing and Care for Older People. Living Well at Home Inquiry, P 7, July 2011.
228 Housing markets and independence in old age: expanding the opportunities, University of Reading, May 2011.
noted in the HAPPI (Housing our Ageing Population) Panel report, published in 2009. Some of the findings are noted below:

(a) **Specialist housing provides opportunities for more efficient provision of local care services.** Older people have a large impact on NHS resources. Yet residents in retirement and extra care accommodation manage better and spend fewer nights in hospital as accommodation is designed better to cope with their needs (nights in hospital are noted as being one of the most expensive items of health care for the elderly). 28% of residents said they could manage better than before the move, 65% said they managed the same. 60% said they found it easier to return home following a stay in hospital. Specialist accommodation for older people can prolong the period between people needing to move into residential care, which again the pressure on social services.

(b) **Specialist housing enables older homeowners to release equity.** Few customers have a mortgage, so many have considerable equity to release. Dwellings bought are 10% to 15% cheaper than the properties sold, resulting in a significant amount of equity release. About 40% are able to withdraw £25,000 or more.

(c) **It boosts local housing markets.** Specialist housing increases general availability of much-needed family-sized housing in areas of shortage. On moving, most residents free up substantial family homes, with two thirds moving from homes with three or more bedrooms to an apartment of one or two bedrooms. 5,000 purchases of McCarthy & Stone properties between 2007 and 2010 freed up housing worth £1.1 billion. The majority of these homes were located in the local market area. It therefore helps moderate local house price growth and can reduce demand for building new, larger properties.

(d) **It provides a higher quality of life for older people.** Specialist housing allows people to maintain their independence. 92% of residents are very happy or contented than before the move. In addition, the “Better Life” report showed that 41% of residents felt their health had improved since moving into specialist accommodation. 64% felt that their sense of well-being had improved. By purchasing an apartment, residents have a smaller household to maintain, and buildings and gardens maintenance is organised and paid for through a set service charge.

(e) **It increases security.** 75% of residents are not worried about being a victim of crime, compared with only 47% of owner occupiers who are non-residents.

(f) **It allows residents to remain part of the community.** The elderly are essential to the health of a local community. Most residents have family and friends in the locality. 99% of respondents’ families were supportive of their parents’ move. Specialist housing also sustains local shopping and other services. 80% of residents use the shops almost daily or often, and over 40% use the library or post office almost daily or often.

**WHAT GOVERNMENT CAN DO TO INCREASE SUPPLY OF SPECIALIST HOUSING**

11. There is huge potential for the private sector to reduce the pressure on adult social care budgets and deliver housing and care solutions for older people through specialist housing. However, this will only be achieved by proactive policies in adult social care, planning and housing that recognise the need for innovation and investment in specialist housing for older people.

12. McCarthy & Stone has three key policy suggestions to help the sector deliver more homes, including:

(a) **A clear Government strategy that connects the care needs of older people with specialist housing.** This should show how the Government will ensure that a diverse and high quality supply of private leasehold housing is available in the future and recognise the role that this form of housing can play in adult social care. The forthcoming DCLG Housing Strategy is one avenue to achieving this.

(b) **Ensure local authority planning, housing and care strategies seek to deliver specialist housing across all tenures.** To date, this market has proved tricky to succeed in because: there is a lack of national guidance; there are complexities in delivering accommodation with care, which puts off many housing providers; there is fierce competition from other users for sites, including fast food chains and supermarkets; a high regulatory burden during the building process; and a general lack of appreciation by local authorities of the demographic need for specialist housing. As such, a sea change is required in how local authorities look at this form of housing. This relies on strong direction from Government and support at a local level. Nationally, the draft National Planning Policy Framework is one avenue where this could be achieved. It should also form a strong part of DCLG’s review of its guidance on Strategic Housing Market.

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231 Results from an independent telephone survey of 496 older people living in McCarthy & Stone developments—2008.
Ev w162  Health Committee: Evidence

Assessment, which are undertaken by local authorities. This should include policies that set out the expectation for local planning authorities to properly assess the housing needs of their older populations (both the extent and range of required house types), as part of the evidence base of their Local Plans, underpinned with verified guidance and methodologies for local authorities and neighbourhood forums on how to go about this.

(c) Treat retirement housing as equal to affordable housing. New build retirement apartments should be given enhanced planning status alongside low-cost home ownership for younger households, which are already treated as a form of affordable housing. Treating all forms of retirement housing as equal in status to affordable housing, possibly by creating a use class specifically for older people’s housing, would help reduce its price and increase availability. It would also allow new competitors to enter the market.

13. These changes would help create a proactive planning policy framework that would encourage greater investment, innovation and higher levels of build in this sector.

CONCLUSION

14. While the Dilnot Commission’s Report briefly notes the role of specialist housing, it does not seriously consider its potential to reduce the pressure on adult social care budgets and limit the need for older people to move into residential care.

15. Given its benefits, particularly in reducing adult social care bills, and the growing need, Government must act now to help increase the availability of specialist housing for older people. Given the information in this note, it is essential that the Government now provides the recognition that this form of housing deserves.

October 2011

Written evidence from Sue Ryder (SC 71)

1. ABOUT SUE RYDER

Sue Ryder is a charitable provider of health and social care services across the UK. We care for people with long term or complex conditions and disabilities. We operate in a range of environments including community care alongside our hospices and neurological care centres.

We work closely with PCTs, local authorities, third sector organisations and local communities in the delivery of care. Our knowledge and experience gained as a provider and partner in the health and social care arena makes us uniquely placed to comment on the interface between health and social care across the care continuum in addition to the development of personalised services.

We recently funded and supported the production of a Demos report, Tailor Made: Personalisation must work for those who need it most, examining the future of personalisation, in particular for adults with complex needs. We have outlined relevant findings of the report below.

2. EXECUTIVE SUMMARY

Personalisation in social care will only be achieved through effective partnership working brought about by multi-service integration, tailoring all services around the individual to support them to live the lives they want. The key points in our submission are:

— The aggressive and challenging social care homecare market in England and its negative impact on providers and service users.

— The importance of personal budgets as a tool in achieving personalisation in social care, but the need to recognise that their presence does not guarantee personalisation, just as their absence does not guarantee an absence of personalisation.

— Our recommendation for a more holistic and integrated approach to personalisation and improving outcomes, achievable by involving central and local government, providers and service users.

3. THE SCALE AND IMPLICATIONS OF EXISTING VARIATION IN ACCESS TO AND CHARGES FOR SOCIAL CARE IN ENGLAND

The problems with variation of access to and charges for social care services in England are undoubtedly getting worse. Sue Ryder has first hand experience of the negative impact of these issues having exited the social care homecare market earlier this year, in part as a result of the challenging environment.

3.1 In August this year we transferred our eight homecare contracts to the private operator Allied Healthcare. Though the reason for this was partly strategic (we wanted to concentrate on providing more complex care) the decision was forced by the increasingly aggressive and challenging market.

3.2 While there has always been variation in the hourly rate fees we received from local authorities, competition over price increased dramatically in some areas with the introduction of framework agreements.
This lowered the amount that we were able to charge. In one instance, we had a block contract to provide 3,000 hours of care a week for a local authority. When this was transferred to a framework agreement we found our hourly rate lowered by the local authority by 63p; reducing the amount we received by almost £100,000 per year and bringing the service into deficit.

3.3 Framework agreements created other challenges; it was hard to build the kind of economies of scale needed to provide a financially sustainable service. In one area there were 16 other providers on the framework; our position was 12th in relation to cost which seemed to be a central determinant for new business. In one instance we know of, a provider reduced their hourly rate by 10% and were told by the local authority that they were still not offering a competitive price; the provider awarded the hours was charging just above minimum wage. It is our view that it is not possible to provide a quality service at this price.

3.4 We estimate that at least 1,000 hours per week are needed for a provider (and in particular a charity without extensive reserves) to provide a financially sustainable service. Service management, staff training and office overhead costs all need to be covered by the hourly rate received; we estimate this is only possible when providing over the 1,000 hours threshold.

3.5 In addition to experiencing problems in building a suitable number of hours, we were also experiencing the effects of local authorities cutting their budgets. We found ourselves delivering more 15 minute calls; we do not believe that this is enough time (particularly when adding in travel time) to provide a quality service that meets most service user’s needs and wishes. We were therefore uncomfortable with the direction of travel which seemed to be moving towards more of these calls.

3.6 In addition to the length of time we were spending on each call, we found ourselves seeing service users with increasingly more complex conditions for shorter periods of time. As a charity this placed us in a challenging position. We were already making a loss on the majority of our homecare services and struggled to fundraise for something that is perceived to be part of state provision. The most logical solution was to exit the market altogether, ensuring that all of our front-line staff retained employment and service users experienced as much continuity as was possible in the circumstances.

3.7 Recommendations

— The government needs to turn its attention towards the marketplace and produce guidance for local authorities to assist them to encourage a healthy marketplace, not one where only those with extensive reserves or market dominance can flourish.

— The assessment process needs to be standardised to ensure that the unacceptable variances between access and provision of services are addressed as much as is possible.

— It is paramount that service users are able to access information, advice and advocacy services to help them to understand what they are entitled to; is their local authority giving them the support they need?

— Taking all of this into account, we believe the government urgently needs to address the funding settlement for social care, putting in place both short and long term solutions. The Dilnot Review must not be kicked into the long grass.

4. THE PRACTICAL AND POLICY IMPLICATIONS OF THE GOVERNMENT’S COMMITMENT TO PROMOTE PERSONALISATION OF SOCIAL CARE, INCLUDING PERSONAL BUDGETS AND DIRECT PAYMENTS

We welcome the government’s commitment to promoting the personalisation of social care as demonstrated in their vision for social care paper. We agree that where care is personalised, and people are given choice and control over how their care needs are met and supported, they can achieve their desired care outcomes.

4.1 Personal budgets have been instrumental for many in changing their lives and ensuring they are able to choose the right care and support for them. Tailor Made, the recent Demos report funded and supported by Sue Ryder, rightly acknowledges the strategic importance of personal budgets in driving a shift from a service centred, paternalistic care system to one where the individual is in control.232 However, we have concerns that personal budgets are beginning to be seen as the solution to personalisation. As Demos suggests, personal budgets do not guarantee personalisation, just as their absence does not guarantee an absence of personalisation.233 Direct payments are the preferred personal budgets of government, and yet for many with complex needs or those lacking in capacity, these may not be appropriate. We agree with the Demos report’s recommendation that “the alternatives to direct payments are developed to become credible alternatives, which can deliver equivalent levels of choice and control.”234

4.2 Personal budgets, and direct payments in particular, will not be appropriate for all needing care. We have concerns about the flexibility of services required when an individual is nearing the end of their life and whether a personal budget is a sufficient tool for achieving this. There needs to be a person-centred approach

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233 Ibid. p 12.
234 Ibid. p.20.
to this, and those who do not wish to manage their own budget, should still be able to have choices over their care.

4.3 Residential care is often in the press; but rarely are the stories positive. This has caused a misconception amongst the public about residential care. People often think of care homes as a place to go to and die. Good providers see them as a place for people to go to live the life they want. The Demos report recommends building more democratic structures in residential care in order to ensure personalisation.235 Though it is not possible for all of those living in residential care to engage in the running of a home, it is possible for everyone to participate in elements of how they receive their care. In the most complex cases, it may be easier to talk to relatives in order to personalise services. Efforts should always be made to personalise services where possible. This doesn’t have to be by changing “big” things. Often it is the seemingly small things such as when to have an evening meal, when to get out of bed in the morning or what activities to take part in that can make all of the difference.236

4.4 Recommendations
— While we are unequivocal in our support for personal budgets, we believe that they will only deliver personalisation if the services available to purchase are suitably personalised. There is a risk that we pay so much attention to the purchaser that providers find themselves left out of the thinking. It is critical that organisations currently providing best practice examples of embedding the ethos of personalisation into their services are able to share their ways of working. It is also important that commissioners, when commissioning on a larger scale, judge providers on how well they personalise their services.
— A level of clarity is needed from the government about what service users should expect from personalised services, and what providers should be delivering, particularly if the “rights” agenda from the NHS Constitution could be expanded into this area.
— We want to ensure that the government’s social care white paper, published next year, addresses all of these issues, and reflects an approach to personalisation that is flexible; not a “one size fits all” application of personal budgets and direct payments.
— Additionally, we would welcome a long term strategy from the government on residential care.

5. The practical and policy implications of the government’s stated commitment to promote integration between health and social care services

We welcome the government’s efforts to formalise their commitment to the integration of services as demonstrated in practice through the establishment of health and wellbeing boards and in policy through the Future Forum 2 consultation and Caring for our Future engagement exercise.

5.1 We are concerned that the rhetoric around integration seems to focus almost exclusively on health and social care without recognising that without housing, transport and welfare services, it will be difficult to achieve true integration. With a focus on keeping people in their own homes for longer, social care will naturally intersect more with these other services. They cannot be ignored, nor can the development of relationships and ways of working be labelled as too complex.

5.2 In their research, Demos spoke to a range of care users who said that the four most important things in their lives were:237
— Retaining their independence.
— Having a job or volunteering.
— Maintaining links with their family.
— Being with people they know.

As this suggests, people tend to articulate their needs, preferences and aspirations in broad outcomes and not in neat service silos. Though the funding for their services are separate, a joined-up approach must be taken if they are to meet their care outcomes. Services need to work together to find out where an individual wants to be, and how each component of their care, be it social care, housing or benefits advice, can work together to help them achieve this.

5.3 Recommendations
— The government and local bodies are pinning a lot on health and wellbeing boards to facilitate the integration between health and care services for individuals. As a start to achieving multi-service integration we support the Demos recommendation to call for the integration of housing in care planning, and stimulation of the housing sector as part of the wider care and support market.238

235 ibid. p.176.
236 Appendix A—Case study: Sue Ryder, Dee View Court, Aberdeen.
237 Tailor Made: Personalisation must work for those who need it most, Demos (October 2011) p 13.
238 ibid. p 175.
Organisations and commissioners must work together. For example, a Sue Ryder supported living service illustrates the successful partnership between a charity and a housing association; and a local authority and PCT commissioner. We hope this sort of partnership will become the norm.]

October 2011

APPENDIX A

CASE STUDY: SUE RYDER DEE VIEW COURT, ABERDEEN

Dee View Court is a purpose built 22 bed residential centre designed as a specialist, self contained home for people living with long term, progressive neurological conditions. Residents live in self contained apartments and have access to facilities and opportunities they would have at home. The houses have recently been repainted; residents were able to choose the colour of their room, curtains and their bed linen and really personalise their rooms as they wanted to. The centre actively engages service user involvement to shape and develop its care offering, including the recruitment of staff.

One resident at Dee View Court is a member of the residents group that feeds back to the care centre manager suggestions on how to develop the service, as well as interviewing candidates as part of the centre’s recruitment process. She comments: “I can live how I want here. I still have a choice and have more independence.”

APPENDIX B

CASE STUDY: SUE RYDER BIXLEY ROAD SUPPORTED LIVING, IPSWICH

Bixley Road is a supported living facility for those with neurological conditions. It runs as a partnership between Sue Ryder, Progress Housing Association, the Local Authority and PCT. Four tenants were chosen from Sue Ryder The Chantry care home and day service who were suitable for more independent living but still needed health and social care support 24 hours a day.

Tenants are given daily support where needed but all collaborate to play an active role in the running of the house. The project has reduced costs for the PCT and given residents an improved quality of life. One of the residents described the change: “I used to live in a home. Now I live at home.”

Written evidence from Citizens Advice (SC 72)

INTRODUCTION

The CAB service in England saw 1.9 million clients in 2010–11 and advised on 6.7 million problems. Of these problems, around 30,000 were associated with adult social care. Seven bureaux have Legal Services Commission contracts to provide advice in relation to community care or mental health. The Devon Welfare Rights Unit, which is part of Citizens Advice, manages the Devon Finance and Benefits Joint Team which uses local bureau visiting officers (funded by Devon County Council) to complete financial assessments and full benefit checks for the county. Tameside CAB provides an information and advice service about local care and related services for older people, and also an advocacy service for care home residents. Tameside Council funds these services.

Adult social care has for far too long been an underfunded and neglected area. We welcome the findings of the Dilnot Commission and of the Law Commission’s review of social care law. The government is now undertaking an engagement exercise on adult social care, entitled Caring for Our Future, in preparation for a White Paper in the spring of 2012. These developments provide the opportunity to transform the provision of adult social care and to highlight its importance for many frail and disabled people.

However, it is difficult to see how it will be possible to provide a service which fully meets the social care needs which exist in the community without substantially greater resources being put into this field. The Dilnot report recommends that its proposals for charging rules and a charges cap should only apply for services to people whose needs are assessed by the local authority as “substantial” or “critical”. The Care Quality Commission (The state of health care and adult social care in England, September 2011) observes: “Evidence appears to show that the reduction in social care budgets and increased demand is resulting in local authorities tightening their eligibility criteria for people to receive state-funded community care.” The implications are that at present and in the future, people with clear social care needs which are less than “substantial” will go without the care they need unless they or their relatives can pay for it. We do not regard this as an acceptable long term scenario.

The situation on adult care funding is bleak. The Association of Directors of Adult Social Services Budget Survey 2011 (May 2011) says that adult social care will provide a contribution to local authority savings in 2011–12 of £991 million, representing 6.9% of the 2011–12 Adult Social Care budget before savings. The
Ev w166  Health Committee: Evidence

breakdown of this is—Efficiency £681 million (69%), Income £84 million (8%) and Service Reduction £226 million (23%). In view of the continually increasing demand for care services, a £226 million service reduction is very worrying. The position becomes more worrying, since it seems very likely that some of the £681 million “efficiency” savings are being achieved by councils reducing payments they make for residential and domiciliary care, with a resulting reduction in the quality of care provided.

A client in her 40s who had brain injury and Parkinson’s Disease felt that she was in an inappropriate care home and was socially isolated. She wanted to move to be nearer to her family and friends. The care home was not near public transport and there were no facilities for a younger person in the home. Her family were having to pay for new wigs which the client needed and treatment from a chiropodist. Social services told the CAB that the additional cost of a care home to meet the client’s social needs would need to be topped up by her family.

A CAB in the South West advised a client who had resigned from her job as a care assistant in a local care home. She had been uncomfortable with the demands placed upon her—she worked alone, unsupervised and had been told by her manager to administer various drugs, even though she hadn’t had any proper instruction. When she raised this issue with her employer, she felt as if she was being told off rather than supported.

An Essex CAB saw a client who had been dismissed by a care agency. Because of a bad back, the client had been off sick for two and half months, and submitted regular sick notes. Her employers told her that they did not pay statutory sick pay, and so she claimed ESA immediately. The client then received her P45 in the post, without any explanation, warning, dismissal letter or pay in lieu of notice.

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 reports from the Dilnot Commission and the Law Commission provide a valuable basis on which the government can set a clear direction for the provision of adult social care in the future. It is to be hoped that the engagement exercise—Caring for Our Future—which the Department of Health is currently conducting will help the government to clarify its plans for other aspects of adult social care. The Department has identified six priority themes:

— quality;
— personalisation of Care;
— shaping local care services;
— prevention and early intervention;
— integration (in partnership with the NHS Future Forum), and
— role of financial services.

A leader, supported by a reference group, has been chosen for each theme. Individuals and organisations are invited to return a generic response form to the engagement exercise, but it is currently unclear whether there will also be opportunities to make detailed contributions to the work on the six priority themes.

We are concerned that the extreme financial pressures under which local authorities will be operating in the next few years mean that, in addition to raising the eligibility criteria to receive adult care services, councils are likely to cut back on preventative and early intervention services. To do so will be counter productive in the longer term, and we hope that the engagement process will bring forward evidence on the benefits that such services can provide and how they can be safeguarded in a time of austerity. Like the Dilnot Commission, we welcome the government’s commitment to re-ablement services that are free of charge. We trust that the government will provide the resources to make this a reality.

The scale and implications of existing variation in access to and charges for social care in England

In most places, adult social care services are only available to very frail or disabled people. This is far from being a universal service. Also the charges made for non-residential services vary substantially from place to place.

Individual local authorities decide upon the level of need a person must have in order to receive social care services. In the face of increased needs in the population and budgetary restrictions, it has become increasingly difficult for people to receive services supported by the local authority. The Association of Directors of Adult Social Services Budget Survey 2011 in May 2011 showed a discouraging picture. Using the Fair Access to Care criteria:

— 13% (19) of councils changed their eligibility criteria between 2010–11 and 2011–12, with 15 councils moving from Moderate to Substantial as the lowest need level they will provide for.
— 4% (6) restrict services to people at the Critical level.
— 78% (116) to Substantial and Critical.
— 15% (22) to Moderate and above.
The practical and policy implications of the Government’ s commitment to promote personalisation of social care, including personal budgets and direct payments

Our views on personalisation were set out in our response to the Dilnot Commission:

“We agree that personalisation is a positive development for many service users. In regard to personal budgets, it is important that people are allowed a real choice whether to go down this route, and for

This means that many people with significant social care needs will only receive services if they can pay for them in full, or if they have friends and families to support them.

A CAB in the North West was approached by a client when social services changed her elderly mother’s care package. Her mother was paralysed and suffered from incontinence, and since 2002 had a care plan which provided her with two carers in the morning and evening to help her getting in and out of bed. In 2010, the service manager reduced the care package so that only one carer would be available to come at 4.00 pm. When the client told the service manager that this meant her mother had no help being put to bed, she was told she had three options: call an ambulance as they would be able to help her into bed, consider placing her in a care home, or leave her in a chair overnight, making sure she was comfortable. When the client pursued the matter with social services they offered the client agency staff to help put her mother to bed. The client was reluctant to use agency staff because of a previous bad experience and her mother’s need for a long-term routine.

A Dorset CAB saw a client whose doctor and carer had advised the social care and health services that he needed care, but was assessed as not needing care. He was then admitted to hospital for his safety, suffering from dementia and the cold. He was assessed as fit to leave hospital after two days, but was not moved into a care home for over four months, as the social services were slow to make another assessment.

CABs also see examples of inadequate assessments by local authorities of the needs of frail or disabled people and their unpaid carers.

A Yorkshire CAB saw a client with physical disabilities and learning difficulties. He lived at home with his parents and brother, who was his main carer. The client attended a day centre three times a week, but the centre was due to start charging. The client’s mother called social services to request an assessment, hoping that he would be given a personal budget and the appropriate advice. She said that when she called, she was asked a few questions, but then told that her son would not receive any support. She hadn’t been given any more information, and she and her son were confused as to his entitlements. Social services appeared to have made a cursory judgement about the client’s level of need, without speaking to him or taking into account the needs of his carers.

A client of a London CAB was concerned that her mother-in-law’s care assessment had been carried out over the phone. The client had requested an assessment, and four months later social services called and said that due to staff shortages, the care assessment would be carried out over the phone. The client said that although they asked the relevant questions, she felt that the assessor should have seen the circumstances in which the mother-in-law lived, which was difficult to describe. The client was concerned that the care package would not be based on an accurate representation of her mother-in-law’s needs.

The charging arrangements for residential social care are specified by the Department of Health (Charging for Residential Accommodation Guide—April 2011) which gives a measure of national uniformity. However, individual local authorities determine how much they are prepared to pay for residents in different types of residential accommodation. Because of their power in the market, local authorities can dictate rates well below what residential homes charge their self-paying residents. This carries a number of dangers: local authority sponsored residents may be treated as second class citizens, self payers may be subsidising LA sponsored residents, homes may be forced to reduce the quality of care they provide, homes may be driven out of business because fees do not cover costs, and families may have to make third party top ups to a relative’s fees. It is disappointing that the Dilnot Commission did not address these market failures, giving no recognition in pages 49 and 50 of their report to the weaknesses which beset the current system.

The Department of Health issues guidance on the way in which local authorities must assess client charges for non-residential social care (Fairer charging policies for home care and other non-residential social services: guidance for Councils with Social Services Responsibilities—September 2003). Within this framework, local authorities have substantial freedom in the fees they set—for example, the hourly rate they charge, and whether or not they set a maximum weekly charge for individuals. In response to their tight funding position, it appears to us that many local authorities have substantially increased the charges individuals must pay in 2011–12. For example an April 2011 report by the Coalition on Charging reports six (out of 15 authorities surveyed) increasing hourly fees by between 9% and 78%. Also that six authorities had completely removed a previous upper limit on the total weekly charges an individual can pay, four others had raised the limit by between £48 and £124 a week, and only three had retained the previous limit. We consider that these variations in charging regimes constitute a postcode lottery, and believe that a national system of charging should be introduced, along the lines of that for residential care.

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the package to include access to support in dealing with the responsibilities this may involve (for example choosing between care providers, becoming an employer of your carers). CABs see too many cases in which people have been pressurised to accept a personal budget when they are not in a position to take on the responsibility, or have received inadequate support from the local authority in spending their budget. It is our impression that frail old people are particularly likely to find it hard to cope with the responsibilities of a personal budget. Some will have family who can help them, but any arrangements for family involvement need to be set up in a way to ensure that financial abuse of the old person does not take place."

A CAB community care outreach in Cheshire reported two cases where the clients have had difficulties managing their own care.

One client with mental health problems got into difficulties with Direct Payments and paying Tax and National Insurance for her carers. This may have resulted in her losing her choice of carer, how her care was provided and security of service for her and her 11 year old son.

An elderly lady reduced her care package to save money, which caused detriment to her health. She did not understand how the system worked and had to repay the money saved to the Local Authority.

CABs also see problems for carers who are employed by people with personal budgets.

A Norfolk CAB advised a client who had worked as carer for someone managing their own care budget. She claimed that she had been unfairly dismissed after taking time off sick, even though she had a sick note. The client also said that the woman she had cared for paid her low wages, and which often came late, and that she had to perform duties such as lifting which she was not trained for.

The barriers faced by recipients of social care when they wish to relocate to another area, particularly with regard to the portability of assessments

We recognise that some service users will have a strong need to move to a different local authority—for example to receive support from close family, or because of a new relationship. The recommendations of the Dilnot Commission will go a long way towards providing portability for service users who are moving from one local authority to another. A more uniform national charging system for domiciliary care, which we advocate above, would also help.

Economic regulation of the social care system including a proportionate failure regime that can mitigate against the failure of social care providers

We are very concerned that it is possible for major suppliers of social care (such as Southern Cross) to get into financial difficulties that threaten the welfare of their residents. We are also concerned that local authorities are able to use their market power to force social care providers to accept levels of payment which are not adequate to allow them to provide a decent standard of service. In residential care, this leads to the problems set out above. In domiciliary care it leads to unacceptable practices such as carers being allowed no time for travel between clients, and not being paid for their travel costs. This is unacceptable for carers who are already on very low pay, and for service recipients who are unlikely to receive the care they need because carers are too rushed.

The practical and policy implications of the Government’s stated commitment to promote integration between health and social care services

It is our experience that people find it difficult to understand the differences between what is regarded as social care and what is regarded as health care. They also find the very different charging arrangements surprising and, often very unwelcome. Too often vulnerable people find themselves caught in the middle between staff from health and from adult care services who are each trying to show that the client is not their responsibility. Over the years there has been a great deal of encouragement from government for health and social services to work constructively together in the interests of the individual service recipient. Again, we hope that the engagement process can come up with concrete proposals for better integration of health and social care, to give substance to the rhetoric which has been around for a long time.

It is unclear to us if the Integration theme will also address the interaction of social care with housing provision. With the increasing (and welcome) trend towards supporting frail and disabled people in their own homes, it is imperative that the practical and financial requirements to support this trend are identified.

October 2011
Written evidence from the British Private Equity & Venture Capital Association (SC 73)

About the BVCA: The British Private Equity & Venture Capital Association (BVCA) is the industry body and public policy advocate for the private equity and venture capital industry in the UK.

The BVCA Membership comprises over 230 private equity, midmarket and venture capital firms with an accumulated total of approximately £32 billion funds under management; as well as over 220 professional advisory firms, including legal, accounting, regulatory and tax advisers, corporate financiers, due diligence professionals, environmental advisers, transaction services providers, and placement agents. Additional members include international investors and funds-of-funds, secondary purchasers, university teams and academics and fellow national private equity and venture capital associations globally.

As a result of the BVCA’s lobbying and reputation-building efforts, private equity and venture capital today have a public face. Venture capital is behind some of the most cutting-edge innovations coming out of the UK and that many of us take for granted: the medical diagnostic services we use in hospitals, the chips in our mobile phones, the manufactured components of our cars, and the bioethanol fuels that may run them in the future. Likewise, private equity is behind a range recognisable High Street brands, such as Boots, Phones4U, Birds Eye, National Grid and RAC.

SUMMARY

— Demographic pressures will vastly increase demand in the social care sector, with the population aged over 80 more than doubling by 2080. With public provision more costly and in decline, the private and not for profit sector will have to pick up the slack.

— Private equity represents a significant subsector of private provision in health and social care, having invested £1.6 billion since 2006. Our services range from supported living, specialist care for dementia and more conventional residential care homes.

— With the private sector contributing significantly to service provision, it is imperative that the market drives up standards and quality. The latest survey suggests that 88% of private residential care homes were rated as good or excellent. However the Care Quality Commission has recently suspended its star ratings system. New metrics should be restored as soon as possible.

— Social care provision involves looking after society’s most vulnerable therefore everything must be done to ensure continuity of care where businesses get into difficulty. It is important to note that care homes do close on a regular basis (175 in the year to March 2010) and continuity of care has been maintained with “little or no impact on residents.”240 However Southern Cross has demonstrated that the measures available are haphazard and poorly communicated which has spread anxiety for residents and their families.

— Rather than new regulations on acceptable business models which would likely deter investment at the worst possible time, a comprehensive and universal failure regime should be consulted on and when devised, properly communicated to all stakeholders.

— The regime for Local Authority Fees has been inconsistent which has rendered the investment climate more difficult and in some cases led to service providers getting into difficulty. To deliver the significant and long-term investment required, this regime should be overhauled to deliver more consistency in pricing.

INTRODUCTION

1. As significant contributors to the health and social care sector, the private equity and venture capital industry welcomes the opportunity to contribute to this enquiry. The UN’s latest population projections see the population of those aged over 80 more than doubling to 9% in the UK or 6.6 million people by 2050.241 By 2081, three and a half times as many people will require residential care.242 This does not include those care recipients who receive it in their own homes. As owners and operators of residential care homes, domiciliary/supported living services and care facilities for adults with learning difficulties, we have a serious responsibility to participate in and contribute to a debate on the future of the sector. It is imperative that to secure the investment needed to deliver adequate provision to cope with changing demographics, but more importantly to ensure that provision delivers a high quality of care for some of society’s most vulnerable citizens, we have a stable and consistent regulatory and funding environment for the benefit of all participants.

WHAT WE DO

2. BVCA members invested £680 million in healthcare providers in 2010 for a total of £1.8 billion since 2006.243 This ranges from large scale care home providers like Southern Cross which was owned by private equity until 2006 and niche care businesses like CASA Ltd, currently owned by Bridges Ventures, a social investment fund. Below are some detailed case studies of private equity ownership in social care.

240 NAO—Oversight of user choice and provider competition in care markets.
241 See http://esa.un.org/unpd/wpp/unpp/p2k0data.asp
242 Laing and Buisson—Care of Elderly People UK Market Survey 2010.
243 BVCA statistics—“healthcare providers” includes social care, domiciliary care and other types of healthcare.
CASE STUDY: SLC GROUP—BACKED BY ISIS EQUITY PARTNERS 2006 TO 2011

3. SLC is a leading provider of supported living services, providing support for adults with both learning and physical disabilities, challenging behaviours and mental health needs.

4. Since 1948, the government has been responsible for supporting adults with mental health needs. Increasingly, though more and more of this provision is by both the private and the independent sector—now as much as 68%. This is a societal need that is growing at 3% a year thanks to improved survival rates at birth and better diagnostics. Supported Living is fast becoming the primary means of delivering this service.

5. In partnership with local authorities, cost effectiveness is increased through contracting by the hour, which supports living as opposed to residential care support. This delivers heightened productivity and value for money for local authorities. It also allows the capacity for innovation in service delivery with flexibility being key for both commissioner and service user—any one user will have different technology needs as well location/property needs. Furthermore a competitive market means quality is paramount and the Care Quality Commission (CQC) recently awarded SLC a three star rating before this benchmark was discontinued.

6. ISIS and SLC: ISIS acquired their stake in 2006 and since then it has built a professional management team capable of driving growth from a founder led business. This led to expansion from a local provider to a leader in the North of England. It has driven a strategy to develop differentiated service offerings in keeping with the increased personalisation of user needs.

CASE STUDY: CARE AND SHARE ASSOCIATES (CASA)—BACKED BY BRIDGES VENTURES SOCIAL ENTREPRENEURS FUND

7. CASA is the UK’s leading employee-owned homecare social enterprise in the social care sector, delivering a range of independent living, home care and support services. Under a “social franchise” model, CASA currently operates five companies across the North of England, providing more than 5,000 hours of care per week. Through operating an employee-ownership model, CASA aims to provide more rewarding roles for employees and better patient care, which in turn allows the company to present a compelling offer to local authorities looking to tender out these services.

8. CASA’s “social franchise” model and resulting benefits: Staff in this typically low-paid industry are awarded a share of the profits from the business, and moreover input into how the organisation is run. This results in a better quality of care for the service-users, particularly as CASA is able to achieve considerably lower staff churn (c.3% to 10% across their different sites—lower in the more established sites) than the rest of the industry (c.24% as private sector industry average).244 Service users generally have one main carer (with others covering illness or holiday) rather than a permanently changing mix as is usually the case in the sector.

9. Through local ownership (each individual site or franchise company is majority owned by local employees), the model ensures surpluses are invested in the local community, while providing employment for those in the most deprived parts of the country (as at April 2011, 72% of carers lived in the bottom quartile of local wards, defined by the Index of Multiple Deprivation).

10. Bridges Ventures and CASA: The investment came from its Social Entrepreneurs Fund which puts social impact ahead of financial return when considering investments. Bridges invested £200,000 through a “social loan” in May 2011 to strengthen the CASA’s core business and provide a robust platform for future growth. With interest linked to CASA’s revenue, investor returns are aligned both to CASA’s commercial success and the scale of its social impact. It is envisaged that further funds will be invested by Bridges to support future roll-out through the employee-owned franchise company model with a mission to greatly enhance the sector by providing more rewarding roles for employees, and better care and outcomes for individuals receiving support.

STATE OF THE CARE MARKET

11. By 2081, 1.5 million people will require residential care and there remains the question of who will provide it? The annual value of the market is £14 billion of which the private sector makes up £9.9 billion. In domiciliary care, 60% is provided by the independent sector.

12. Demand is set to increase though with total occupancy across all provider types increasing from 418,000 today to 437,000 by 2020, an extra 19,000 places. However as the below indicates, public sector supply is reducing so the private sector must add capacity.

13. It is also worthy of note, that where public sector provision pertains, it is far more expensive than private provision. Data published by the NHS Information Centre shows a per resident cost of £824 per week in 2008–09 vs £445 for “other” providers. In this time of spending restraint for Local Authorities, it is predictable and necessary for this trend of greater reliance on private provision to continue so private investment into the sector must be encouraged.

CASE STUDY: VOYAGE BACKED BY HG CAPITAL

14. Voyage is a leading provider of high acuity services for adults with learning difficulties. There are an estimated 800,000 people in England with a learning disability, of 137,000 receive some sort of support. 80,000 of these are in a residential setting and the vast majority of these services are funded by Local Authorities. Much of the provision is commissioned in the independent sector as costs in Local Authority provision are 40% higher. There is a significant shortage of residential provision of this type so securing more investment is vital.

15. In what is a highly fragmented market of 75,000 beds, Voyage is the market leader with 1924, specialising in moderate to severe learning disabilities and challenging behaviour. Voyage covers the full spectrum of learning difficulties in either a residential, supported living or own-home setting. With near complete coverage in England as well as facilities in Wales and Scotland, Voyage provides over 250 services across the UK, supporting 2,000 individuals.

16. A key strength is longstanding relationships with PCTs and local authorities based on a reputation for high quality provision. Over 95% of Voyage’s registered services rated good or excellent in 2010 and this has increased from 75% in 2008 (HG Capital invested in 2006).

QUALITY

17. With the private sector likely to continue its pre-eminence, legitimate concerns about quality will be raised, particularly in light of service being provided at significantly lower cost than local authority provision. Unfortunately the CQC recently ended its “star ratings” regime for care homes in favour of new, universal measures for social care and all other health care services. At this stage we do not when this scheme will be up and running. Laing and Buisson described this rating system as “a significant driver of quality”. Indeed the final L&B analysis of CQC data as of June 2010, show that 88% of private home operators scored good or excellent (as against 94% for voluntary sector). It is important that there is a drive to get both of these sectors to as close to 100% as possible so a new ratings system and inspection regime must be agreed as soon as possible.
GOVERNMENT POLICY

18. In its Vision for Adult Social Care, the Government reiterated a commitment to the personalisation of services in the context of a vibrant and diverse market for social care services. As can be seen from paragraph two, BVCA members are significant investors in this market as well as representing the whole spectrum of provision and support services from large scale care homes, to small scale in home care operators. We believe that fostering such a market is vital to drive innovation and improve quality of care. It is that ability to innovate that attracts private equity and venture capital to invest in the sector.

19. We do though recognise that there is nothing more important, nor sensitive, than how we look after society’s most vulnerable. So when we talk of market entry and exit it is important to keep in mind at all times, the service users and how they might be impacted by any change in ownership. Continuity of care is paramount. The National Audit Office, in its recent report Oversight of user choice and provider competition in care markets, concluded that entry and exit in both care homes and domiciliary care provision is a common feature of care markets and invariably, other providers come in to run services with no little or no impact on users. However they also stated that more work was needed to protect users from provider failure.

20. A Discussion Paper from the Department of Health, Oversight of the Social Care Markets puts this relative success in care continuity down to a lack of concentration in the market. Before the ongoing closure and transfer of Southern Cross care homes, the largest four providers made up 23.7% of total provision.\(^2\) This is also a figure in decline as condition in credit and property markets have become more adverse. This level of consolidation compares favourably with other markets but it is an issue that should be monitored carefully. In recent testimony to the Public Accounts Committee, the Permanent Secretary for the Department of Health was asked by members to put a number on acceptable market share, either nationally or locally. Naturally she was reluctant to do so and we understand this approach as there is no magic number. What is more important is that where one provider is gaining market share, there should be adequate safeguards should they get into difficulty. The transfer of homes from Southern Cross to new providers is ongoing and so far has been successful but we must make sure that best practice is assessed and that a formal regime is incepted and communicated.

FEES

21. With labour costs making up around half of the total for care provision, the relationship between wages and Local Authority fees paid will go some way to determine the viability of investing in the sector—as of April 2010, 52% of independent care home residents had their fees paid by local authorities. But this primary source of revenue has been highly changeable. Indeed in the last 15 years, Laing and Buisson cite three different periods of funding. The first was from the mid-nineties to the turn of the century where the sector struggled with lack of demand and under-capacity and such Local Authorities imposed RPI fee increases whilst wages accelerated faster. By 2002–03, under-capacity had been largely dealt with and fee increases were running at 8%, significantly above wage and price inflation. However this “golden period” soon ended with public spending restraint leading to fee increase of just 0.8% for 2010–11—significantly below care home cost inflation. Laing and Buisson estimate that 2.1% increases are required for margins to be steady. Such chopping and changing creates significant uncertainty for investors. The Government should consult on a mechanism for fee stabilisation so investors can plan and implement long term strategies.

FAILURE REGIME

22. We have seen this debate play out in banking, with continuity of service being paramount for so vital a function. Social care provision is surely even more important. Given that preventing market exit and particularly entry is not desirable, we would emphasise the importance of a sensible failure regime over onerous restrictions and interventions on business models and financials. It should not be for the CQC, the Department of Health or Local Authorities to determine what is risky behaviour, after all this is a private market. However because in social care we are dealing with society’s most vulnerable, a failure regime that guarantees continuity of care is a must.

23. Our starting point is the same as that of the Department of Health who stated that new measures should encourage rather than hinder the market and not place “undue burdens on businesses”. We would caution against onerous restrictions on acquisition as this will likely curtail investment significantly. It is the medium to long term health of the company that is of greater importance. Southern Cross was in sound financial health both when it was acquired and sold by private equity. However, proper monitoring of its period in public ownership would have highlighted the subsequent deterioration.

24. The Government has mooted the model used by the travel industry whereby licensed providers pay for a bond that covers the cost of repatriating holidaymakers in the event of provider failure. A similar model could be used in social care and certainly warrants further study. This would be much simpler than asking the

\(^2\) Laing and Buisson.
CQC to regulate business models of providers either pre or post acquisition, it would guarantee continuity of care and should have a modest impact on investment into the sector.

October 2011

**Written evidence from UNISON (SC 76)**

1. **Reduction of Public Expenditure of Social Care Services in England**

   1.1 UNISON has collected a variety of evidence to show that social care has been hardest hit by austerity measures in public funding and more cuts are likely in 2012–15 raising the question of what kind of social care system will be left to provide a care system fit for the future.

   1.2 The Kings Fund predict a funding gap of £1 billion by 2014 (middle case scenario) or by 2014–15 the funding gap widens to around £2.2 billion (worse case scenario)—about 15% of the actual spend in that year.246

   1.3 Recently both Andrew Dilnot, who published the latest government report on long-term care funding, *Dilnot Commission on funding of Care and Support July 2011*, and Richard Harbord, chair of the influential adult social care panel of the Chartered Institute of Public Finance and Accountancy (CIPFA) called for “increased financial support” for adults and children’s services.

   1.4 These calls are significant as it shows how far council finance chiefs and Commissioners reject ministers’ case that local authorities can maintain services through efficiency savings and service transformation, in the face of substantial funding cuts.

   1.5 Harbord is also chief executive of Boston Council in Lincolnshire and said that authorities could only manage to maintain statutory care services by cutting back more from non-statutory areas of children’s and adults’ services.

     "There’s no doubt the services are underfunded so the choice of taking more out will be very difficult to manage if not practically impossible."

   (Cipfa’s annual social care finance conference. *Community Care magazine July 2011*)

   1.6 Examples of Largest Local Authority cuts England: £22 million in Nottinghamshire, £33 million in Lewisham and £17.5 million in Birmingham in 2011–12 and Durham County Council to cut £125 million from its budget over four years (*Community Care magazine June 2011*)

2. **Personalisation of Care**

   **Unison** is concerned that “personalisation” is now being hijacked by the cost-cutting agenda because it has made it easier for councils to shift the burdens on to families.

   2.1 The recent impact of cuts combined with the underfunding of personalisation and the government’s “preferred method” to have all care recipients receiving care through Direct Payments by 2013, has heightened the concerns that UNISON has already raised. Evidence shows that Direct Payments are being used as an excuse to close down care services in communities and make cuts in public services rather than complement existing services.

   2.2 The roll-out of personal budgets will only deliver personal value for money if councils take steps to increase choice for users in the social care market. The National Audit office has made it clear that this will be difficult in the current funding climate. The report highlighted the problems in some areas:

   - A shortage of service providers.
   - High rent in some urban areas as a problem for new providers.
   - A shortage of personal assistants, brokerage services and support for people with complex needs.
   - Lack of resources had limited attempts by local authorities to encourage new providers into the market.
   - Recruitment difficulties among providers with many potential staff put off by low pay, which was doubly worse in isolated and sparsely-populated rural areas.
   - Arrangements to protect social care services from the failure of large providers, in the light of the Southern Cross case.*

   (National Audit Office. *Oversight of user choice and provider competition in care market, September 2011*)

   2.3 Further more research shows that choice of service provision and budgets has not been upheld in some local authorities’ provision and funding is being provided as a straight choice between been given either a council service or a direct payment when in principle it could be a mix of cash and a service. That is a real choice.

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The key effects of underfunding personalisation on social care jobs and services:

- Downgrading and downsizing adult social workers roles.
- Privatising and commissioning out homecare workforce.
- Restructuring services and integrating services.
- Closing down or increasing prices in social care services eg day care centres, community transport, meals on wheels.
- Closing down and privatising residential care.
- Increase in agency and Personal Assistant (PA) workforce.
- No national regulative or registration framework for micro-employers and PAs to meet all their legal responsibilities as employers and employees and be clear of their employment rights and responsibilities.
- No clear career progression path in new personalised workforce due to lack of training costs in Personal Budgets—Direct Payments.
- Few PAs training schemes—mentoring and wider skills other than organised around a DP holders particular individual needs.

3. IMPACT OF CUTS ON SERVICES

3.1 To cope with underfunding of social care local authorities have attempted to ration social care by raising prices and thresholds:

88% of councils have increased their charges. (Community Care Magazine March 2011)

In 2005 half of councils provided support to people assessed as having “moderate” needs, but in 2011 the figure has fallen to 18%. As a result the number of people receiving local authority funded care at home has been slashed from 489,000 in 2004 to 299,000 in 2009. (Care in crisis: causes and solutions Age UK May 2011)

3.2 The result has been an increase in the post code lottery and legal challenges. The number of legal challenges to council social care policies rose by 45% 2010–11 (Legal claims on council social care policies up by 45% Community Care August 2011).

3.3 A brief look at what is happening to a range of individual services in social care reveals a bigger picture of where these services are being stripped away from service users. This can be devastating for services users who may use a combination of these services and in particular the removal of the social side of a service can have a significant impact on an individuals and families mental health and stress support.

4. DOMICILIARY CARE

4.1 The growing evidence of the negative impact of underfunding on domiciliary care has revealed not just a problem with an increasing poorly paid workforce but also poor quality care provision.

4.2 There is an emerging fault line in the way that care is now being commissioned and provided affecting quality and safeguarding in care services.

4.3 The UKHA survey of 111 councils reveals reductions in home care support and payment to providers:

- 82% of councils had cut the visiting times allocated for at least some service users. The average visit fell from 48 to 38 minutes and visits of 15 minutes were increasing.
- 75% of councils had reduced the number of daily visits. An examination of 50 individual cases found that most had had reductions in support such as safety check visits, social contact visits, and help with personal care, shopping and managing finance.
- 58% of councils had cut their funding to independent providers; half had removed the unsocial hour’s premium and a fifth were reducing payments for travelling time.
- There was some evidence of staff being paid by the minute for visits.
- Rural services were particularly affected by reductions to travelling time. 10% of providers indicated they had turned down work in rural areas.
- Terms and conditions of workers were being cut; in some areas, particularly the NW and NE, it was difficult to pay staff much above the minimum wage.

UK Homecare Association (UKHCA) Survey Service users at risk September 2011
4.4 These findings reinforce the fact that the care system in England is under-funded by around £2 billion a year (ADASS September 2011). Local authorities are passing on the underfunding through commissioning which some officers have claimed have forced them to accept “suicide bids”.

4.5 UNISON has received evidence from its branches where Councillors are also reducing the amount of providers they are awarding contracts to achieve economies of scale. This is making the voluntary and community sector and small charity programmes unsustainable and less viable:

- Buckinghamshire County Council reduced its care providers from forty-plus to four.
- Dorset County Council has reduced funding to providers from 86 to six.
- Wilshire County Council has reduced funding to providers from 120 to four.

5. **INDIVIDUAL SUPPORT SERVICES**

5.1 This service has suffered from closures or price increases due to reduced funding to contractors, increased privatisations and the use of frozen meals delivered less frequently and encouragement of elderly people to buy frozen meals from supermarkets instead.

5.2 Traditionally Community Care transport providers and Day Care centres relied on block contracts from local authorities to fund their service provision. Evidence shows that they have become the casualties of personal budgets, underfunding and commissioning changes.

5.3 Instead of purchasing services in bulk from available providers and offering eligible service users those services that best meet their needs, Commissioners now only promote the availability of services from which service users can choose.

5.4 Personalisation has therefore required a change in approach from care providers. As councils devolve purchasing responsibility to service users, providers can no longer rely on block contracts with local authorities. Instead, most councils are setting up framework agreements, under which providers are accredited to provide services of a particular quality at an agreed price but are not guaranteed business, as decisions on whether to use them rest with service users.

5.5 This trend has created large casualties, particularly in the closure of services that remain in demand but can only be sustained by a critical mass of service users, such as day centres. In these cases, even though the elderly and families and carers have expressed wishes to have these services maintained the lack of block funding has not made this locally viable.

5.6 If block funding is removed then neither local authority nor a voluntary and community group provision of a service can be sustained within a fragile financial funding environment. The service is no longer viable even if a minority of users cease to use it regardless of the majority’s wishes to have it maintained.

5.7 It is now becoming much clearer how the cuts are affecting funding of CVS and specialist care organisations dealing with children and families, elderly and disabled with specialist needs. A range of support and advocacy services in HIV, Alzheimer’s, strokes, dementia, disability support, homelessness, mental health and general support for families needing help with caring are being lost.

5.8 In total it is estimated that the voluntary and community sector stands to lose £2.8 billion public funding over the current spending review period running from 2011–16

*(Counting the Cuts: The impact of spending cuts on the UK voluntary and community sector is a new report published by the National Council for Voluntary Organisations (NCVO) August 2011)*

5.9 UNISON has concerns that mental health services are likely to have more pressure put on them due to funding cuts in both social care and the NHS. The NHS has to make £20 billion efficiency savings by 2015 and this will undoubtedly have affects on social care frontline services which will come under increasing pressure. In particular mental health patients will suffer on the back of the 50,000 NHS jobs cuts revealed by False Economy FOI research (February 2011):

> “Some mental health trusts are planning to shed 15% from their workforces, with total NHS job losses likely to hit 53,150.”

6. **CRISIS IN RESIDENTIAL CARE HOMES**

6.1 The makeup of residents in care homes are

- 40% private payers.
- 52% local authority funded.
- 8% NHS funded.
6.2 The Residential care home services crisis can be summed up as:

— Public care homes being shut or sold on to the private sector despite having the highest quality of standard rating.
— Residential Care homes are mainly concentrated in the private sector and 6/10 rely on public funding which is declining.
— Business models in residential care typically rely on an average 90% occupancy rate. This has fallen by 2% to 89% since 2008 (Laing and Buisson 2010).
— Due to underfunding private care homes are reducing their services, staff and places offered.
— The care home industry has suffered as a target of private equity, stripping away the property values and leaving the rest of the business financially vulnerable.
— A consolidation in the sector with a trend for new residential home cares to be larger squeezing smaller providers. The market share of the four largest care home providers was 23.7% (Laing and Buisson 2010).
— Inadequacies of residential homecare management and staff training and whistle blowing have been repeatedly revealed with reports and undercover programmes revealing the mistreatment of adults with disabilities and the elderly.
— The lack of credible resources of regulator Care Quality Commission (CQC) have been exposed with its inspections cut by 70% between 2010–2011.

6.3 In a recent press release report UNISON used the example of the failure of the UK’s largest care home providers Southern Cross—with its 31,000 residents and 40,000 employees in 755 homes—to show how the marketisation of social care services and particularly residential care has culminated in the private sector taking the profit and the public sector taking the risks.

6.4 The failure of the UK’s largest home care providers Southern Cross, which ceased trading in 2011 with 755 Southern Cross homes to transfer, reveals the dependency on local authorities to pick up the pieces when the private market fails. It further highlights the urgent need for commissioners and providers to work more transparently in financial regulation of local care services. Some local authorities were given less than two months to find new proprietors or prospective operators to ensure a smooth transfer causing considerable distress and uncertainty to staff and service users.

7. UNISON SUPPORT FOR FINANCIAL REGULATION OF CARE PROVIDERS TO ENSURE PROTECTION

7.1 UNISON is concerned that many of the large care home providers are involved in private equity debts and are operating on negotiated long term debt restructuring basis. There is evidence that the five largest UK residential care providers Four Seasons, BUPA, Barchester Healthcare and the Priory are linked to private equity firms with an interest in financial profits in residential and domiciliary home care provision. This is not a sustainable basis for providing protection to residential care services.

7.2 UNISON will be responding to the DH Oversight of the Social Care market Discussion paper consultation October 2010 which has set out a variety of measures and proposals to address the heightened risk associated with financial failure amongst the group of large residential care providers.

8. QUALITY OF CARE IN CARE HOMES—DIMINISHING STANDARDS

8.1 The crisis in funding and marketisation has also occurred alongside increased concerns over the quality of care being provided. In particular human rights and dignity have been focussed on by highly publicised reports in the BBC Panorama programme on Winterbourne View care home Hospital June 2011 and the EHRC Inquiry into homecare of older people 2011.

8.2 Along with rising concerns of quality of care there has also been a concern over the findings of care provision inspections and the regulation role of the Care Quality Commission (CQC):

— Just 51% of nursing homes were fully compliant with the standard on care and welfare. This compares with a full compliance rate of 68% for residential homes and 73% for homecare agencies.
— CQC identified major concerns on care and welfare in 10% of nursing homes, 5% of residential homes and 3% of domiciliary care agencies.
— In September 2011 the Health Committee reported that the CQC had cuts inspections by 70% and was guilty of a “significant distortion of priorities” when it valued the registration of health providers above its core function of inspection. (Health Committee, Ninth Report, Annual accountability hearing with the CQC, September 2011)

8.3 UNISON who represent CQC Inspectors welcomed the report stressing that a minimum number of inspections is the cornerstone of compliance checking and the number of inspections need to be balanced with the right amount of time spent and checks done.
9. **SOCIAL ENTERPRISES, CO-OPERATIVES OR MUTUALS DELIVERING SOCIAL CARE**

9.1 There is relatively little experience and diversity in social care providers operating as mutuals, co-operatives or social enterprises in providing sustainable long term public care services.

9.2 UNISON has concerns that these models are being promoted currently as a viable alternative to public services when in fact they may be merely used as a way of delivering public spending cuts or worse be used as a step towards or dressing up wholesale privatisation plans.

9.3 UNISONs experience particularly in the South West region with social enterprises are that the vast majority of social enterprises are being introduced as management-led initiatives, in which employee engagement has been little more than an afterthought. Staff have been encouraged to favour social enterprise through the “right to request” scheme in PCTs but with little information or discussions on the long term security of the enterprise and jobs.

9.4 Despite massive pushes from the government, only 10% of services are set currently to become social enterprises under the scheme. UNISON believes that even amongst this limited number, many will not be able to go ahead due to a lack of buy-in from staff.

9.5 UNISON has set out in numerous publications its concern with social enterprises, mutual and co—operatives. *Mutuals—questions to ask and Mutuals and public services (June 2011).*

9.6 UNISON believes the focus on mutuals to deliver social care services are part of the Government’s wider drive to restructure the public sector and the Health and Social care sector. The White Paper Open Public Services 2011 sets out plans to increase public service delivery by mutuals as part of wider private service delivery whilst the Health and Social Care Bill 2011 introduces private competitive commissioning in health and social care.

9.7 Mutuals, social enterprises and co-operatives will have to compete with all providers in a competitive market for care services, pitting them against private sector providers. This will actually cause services immense harm:

— Private companies (especially large equity funded) are likely to undercut community based mutuals by offering basic services provided by low-paid staff and providing economies of scale.

— Mutuals may not have the capacity to deal with being legally responsible for health and safety, equalities and disability discrimination, financial reporting, data protection, contract law, etc as well.

— Mutuals don’t have to have “asset locks”—so any public assets transferred from the public sector to mutuals could end up in the private sector.

— Mutuals will be able to take profits out of the services they provide—rather than re-investing in services.

— Marketisation creates more bureaucracy as each “spin-out” has to spend money on bidding for contracts, human resources, legal, finance, sales and marketing.

— Saving on staffing costs is a major driver behind the push towards mutuals taking over public services—taking staff out of public sector pension schemes, for example, reducing pay and conditions such as freezing pay and reducing leave and sick pay.

10. **CUTS AND IMPACT ON THE SOCIAL CARE WORKFORCE**

10.1 National Totals of Voluntary Early Retirements (VER) and redundancies:

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LRD/UNISON 2007–2010 redundancy FOI regional reports August 2011 VER = Voluntary Early Redundancy and R = Redundancy
10.2 UNISON research (based on an 80% Local Authority Freedom of Information return rate) has already shown that approximately 3,400 jobs in social services and the care services have been lost between 2007 and 2010. These job losses were recorded before the bulk of Local authority cuts were implemented in 2010 and 2011 and this report supplements these statistics further by looking at further cuts in jobs and services between 2010 and 2011.

10.3 Key National Headline findings Figures:

- Approximately 3,400 jobs have been lost over the last three yrs in Social Care.
- Care workers jobs are 77% of the job losses and 23% are in Social Services jobs.
- Homecare and Residential care is 43% of the job losses in the total national Social Care group.
- The spread of the total number of job losses have been more or less even over the three year period with 32% (2007–08), 32% (2008–09) and 36% (2009–10).
- This pattern is approximately the same for all groups in Social Care except for Care managers (48%) and Day care workers (47%)—where nearly half the job losses occurred 2009–10.

10.4 Key National Headline findings Analysis:

- The total of approximately 3,400 job losses have been split evenly over the three years showing that the cuts had a 4% increase impact on Social Care job losses overall in 2009–10.
- However in every Social care job category there was an increase in job losses on the previous year of 2008–09 and for some on both years 2007–08 and 2008–09.
- This is except in the Day Care Workers and Care Managers job losses which had a more significant impact, where job losses in 2009–10 nearly doubled on both previous years. This shows that these care worker groups had the most job cuts applied to them in the first round of cuts 2009–10.
- Workers in Day Care centres (UNISONs evidence is due to local authority closure of Day care centres amidst claims that personal budgets has made them unsustainable).
- Care Manager roles which were reduced as restructuring created fewer managers with more staff to manage individually. Also as homecare and residential care workers have been significantly cut so were Care Manager posts reduced.
- The other significant group was Residential care and Homecare workers which have had the overall largest job loss in all three years consistently. These job losses represent the increasing outsourcing of homecare and the selling of residential care by local authorities.
- Social Worker posts have had a total job loss of 187 jobs. A significant amount and UNISON evidence is that this is likely to have been in adult social care rather than children’s social care.

11 Key Workforce Trends

11.1 Changes in sectors:

- Staff cuts on the frontline in all care roles and functions of care are being introduced in the public sector. Approximately 1,245 local authority jobs were lost 2009–10.
- The unregulated and unregistered Personal Assistant workforce is now one fifth of the workforce:
  
  Percentage of jobs by sector:
  
  Local authority—11%.
  
  Independent—65%.
  
  NHS—4%.
  
  Direct payment recipients—20%.

“The number of personal assistants (PAs) in England increased by 35%—92,000 post—in 2009–10 and now accounts for one-fifth of jobs in the adult social care market. The number of jobs in the sector rose from 1.7 million to 1.77 million.” The
size and structure of the adult social care sector and workforce in the England 2011
Skills for Care

11.2 Downgrading, deskilling and lack of training opportunities:
— Professional groups (6% of the care workforce) and workers are reporting that vacancies are not being filled in vital care functions such as adult social workers and occupational therapists needed to assess the elderly and prevent long periods of bed blocking. Instead professional duties are being passed down to staff who have not been offered professional training in these duties.
— Lack of career and training opportunities are key concerns raised by staff and service users.
— Some Authorities have had to stop transferring service users to contracted companies due to the high volume of complaints and the fact that the company was not properly staffed with trained personnel (Aylesbury, February 2011).

Changes in Terms and Conditions
— Wages have gone down consistently in all three sectors: the average pay for care works was £6.00 ph compared to £6.75 two years ago.
— Now the National Minimum wage has increase to £6.08 UNISON is concerned that between 15–20% of the care workforce will now be below the NMW.
— Turnover has gone up the turnover rate of care workers in the private sector is now 25%.
— Reduction in pay as well as freezing pay care workers are being asked to take further cuts in pay and conditions by removing car allowances, unsociable/overnight pay.
— Worse still some authorities are asking workers to stay on call at home without getting paid unless they get called out. UNISON has examples of workers on 34 hour contracts being asked to be on unpaid call for up to 10 hours per day.
— Clarity over the European Working time directive is needed in employment practices by providers. 

October 2011

Written evidence from Body Positive Cheshire & North Wales (SC 77)

I am writing to you regarding the need for the continuation of funding and support towards the provision of Social Care organisations such as Body Positive Cheshire & North Wales (BPCNW) who offer valuable resources to people affected by HIV & AIDS.

Issues this covers:
— Current provision of Social Care in HIV.
— Importance of continued recognition of HIV services.
— Stigma and Discrimination.
— Isolation, mental health, adherence to medication.
— Primary and Secondary prevention.

1. The stigma and discrimination surrounding an HIV diagnosis continues to be a problem and a very real fear faced on a daily basis by people living with HIV (PLWH). Issues around disclosure, access to health care, employment, housing and benefits advice are all hurdles that HIV positive people face. Recognition through funding and specifically the AIDS Support Grant (ASG) has over several years acknowledged these issues and given HIV services the chance to support and improve the quality of life of those diagnosed with HIV.

2. The Department of Health allocation of specific funding to Local Authorities demonstrates a commitment to supporting people’s social care needs when faced by the impact of an HIV diagnosis. Historically the acute service needs developed around the short life expectancy of individuals diagnosed HIV positive. These services have evolved with the introduction of Highly Active Anti Retroviral Treatment (HAART). The development of this medication has enabled people to manage their condition and has improved quality of life. However, medication does not address the potential enduring mental health problems, housing, poverty, employment, disclosure, stigma and discrimination faced whether that be through inappropriate experiences in employment or accessing services where ignorance prevents the correct treatment being offered to people living with HIV.

3. The long term effects of HIV have proven a burden on the NHS when non adherence to medication becomes an issue for patients, leading to increased hospital admissions. Social Care services work holistically with every aspect of a positive person’s life. The ASG not only helps our clients access much needed support but also helps people to access NHS services. Needs are addressed in a preventative way helping individuals to engage with services, retain independence and participate in the community by sharing experiences. This not only keeps awareness of sexually transmitted infections and HIV on the agenda but contributes towards challenging the stigma and discrimination that people with HIV experience.
4. HIV communities continue to experience stigma with individuals finding it difficult to engage with main stream services if they engage at all. Fear of discrimination only polarises people to withdraw and become more isolated. Mental health issues become acute and motivation to adhere to medication thus becomes a real challenge. Input from statutory services ultimately becomes imminent. Without the ASG, this is the extra challenge mainstream services will face.

5. Client case loads managed by BPCNW in the year 2008 increased by 28% from the previous year. In 2009 this increased by a further 34%. BPCNW has had a long term relationship with health services and Local Authorities and is recognised as a provider of specialist Social Care in the HIV field. This work could cease should the ASG be withdrawn. HIV positive people will continue having complex needs despite financial pressures and funding cuts and in the long term this will present an increasing burden on health care services as needs go unaddressed at the appropriate stage in managing a positive persons chronic condition thus leading to mental and physical ill health.

6. Cheshire is a rural County where HIV positive people are reticent about identifying themselves and engaging with main stream services. BPCNW works with 90% of people diagnosed HIV positive within the county in collaboration with Sexual Health Clinics. The work carried out in conjunction with clinical staff has been very successful in dealing with the HIV condition. This has addressed people’s needs in an holistic manner and at a very competitive rate.

7. Research clearly shows that levels of late stage diagnosis remains high, with the Department of Health keeping this as one of the National Health outcomes. PLWHIV are living longer and experiencing additional health challenges as a result of their condition. HIV diagnosis amongst older people remains high, suggesting that messages about safer sex and awareness are not being heard. This will add to the increase in complex Social Care needs of the elderly.

8. Sexual health issues continue to be regarded as a low priority and are very unpopular within communities despite numbers continually increasing due to a lack of awareness and poor concepts of sexual health and well being. HIV services not only challenge this amongst people living with HIV but also within the communities that they work in. Trust Funds and other grant making bodies are reluctant to offer part funding for this work if at all and the removal of funding for HIV Social Care can only have a detrimental effect to the services offered by organisations such as BPCNW.

October 2011

Written evidence from Scope (SC 78)

1. ABOUT SCOPE

1.1 Scope is a leading disability charity that supports and works with disabled people and their families at every stage of their life. We believe disabled people should have the same opportunities as everyone else and we run campaigns with disabled people to make this happen. Scope operates in England and Wales and provides localised, individual care and support, residential, information and advice, employment and education services for disabled people and their families. As a charity with expertise in complex support needs and cerebral palsy we never set limits on potential.

2. EXECUTIVE SUMMARY

2.1 For many disabled people the provision of high quality, tailored, social care can be the difference between living in isolation, or living a full and independent life. It is crucial that in shaping the future of social care provision in the UK, the needs or working age disabled people are adequately considered and addressed. Scope believes that the adult social care system must be simplified and better funded to meet the needs of working age disabled people and must focus on providing support for people to live independent lives, in their own home, and to give them the opportunity to play an active role in society.

2.2 Scope is extremely supportive of the Dilnot Commission’s recommendations that all those who enter adulthood with a care and support need should be eligible for free state support immediately rather than being subjected to a means test and that national eligibility criteria and portable assessments should be introduced to ensure greater consistency. We feel strongly that these recommendations need to be reflected in the Government’s forthcoming White Paper on social care.

2.3 Scope has serious concerns about the impact of local authority budgetary cuts and the ending of ring fencing of all revenue grants. Despite the extremely welcome £2 billion of additional funding to support social care announced by the Government by 2014–15, plans to phase out ring-fencing of central Government grants to local authorities means that there is no guarantee that this funding will actually be spent on social care provision.

3. FREE SOCIAL CARE FOR ALL WORKING AGE DISABLED PEOPLE

3.1 The changing demographics of the UK will inevitably lead to a greater demand for social care services. Along with the challenges that an aging population will present in providing high quality social care, advances
in medicine and technology mean that more young people with complex needs are living for longer and well into adulthood.

3.2 Scope believes that all eligible working age disabled people with a care and support need should automatically be entitled to free state support. This recommendation was also made by Professor Andrew Dilnot when he recently led the Commission on the Funding of Care and Support, and Scope warmly recommends his findings in this respect. Scope agrees with the report that those who enter adulthood with a care and support need should be eligible for free-state support immediately, rather than being subjected to a means test.

3.3 A disabled person who has entered working age with complex support needs may not have had the same opportunity to work, save and make National Insurance contributions. It is therefore unfair to expect someone in this position to be means tested in order to receive social care. Furthermore, this proposal will also help smooth the transition from children’s services to adult social care.

3.4 The means testing threshold for social care eligibility provides a significant barrier for disabled people who wish to save. The current threshold of £23,250, instead encourages disabled people to dispose of any assets above this amount in order to remain below the threshold and remain eligible for free social care. The ability for disabled people to withstand unexpected financial shocks is therefore greatly reduced by the difficulty they experience in accruing savings and assets. In order to encourage disabled people to save, accrue assets and become financially resilient, it is essential that free social care is available to all working age disabled people.

3.5 The receipt of high quality social care can often make the difference between a disabled person being able to work or not, and can have a huge impact on their ability to contribute to the economy and engage in society.

4. Eligibility Criteria

4.1 Last year, 72% of councils were restricting access to free social care to those assessed with “substantial” or “critical” needs only. Scope is extremely concerned that despite the £2 billion investment in social care, more and more councils will be forced to raise the eligibility criteria for social care support to these higher levels. Birmingham Council were recently forced to drop proposals to raise the criteria to “super-critical” following much controversy.

4.2 A rise in eligibility criteria would result in more disabled people currently living independently in the community with support, being forced into costly residential services. Furthermore, those who rely on social care services as a prerequisite to employment (for assistance with getting out of bed, dressing, bathing and eating) may also be forced to leave their jobs. The situation will also develop that disabled people and their families will have to use their own savings—where they have them—or borrow money from high cost lenders to subside or fund their social care needs, pushing more disabled people into poverty.

4.3 The impact of an increase in eligibility criteria will be compounded by proposed changes in the Welfare Reform Bill to abolish Disability Living Allowance (DLA) and replace it with a new benefit called the Personal Independence Payment (PIP). Scope has significant concerns that the assessment proposed by the Government to determine eligibility for PIP will not target the benefit at those who face the greatest barriers, and would benefit most from additional support.

4.4 As a consequence of local authorities raising eligibility thresholds for social care, many of those assessed as having low or moderate support needs are using their DLA payments to cover social care costs that are no longer met by the local authority. We are worried that fundamental flaws in the Government’s assessment process for PIP will mean that many of this group, who may have low impact of impairment but high disability costs, will no longer receive any state support to cover the costs of their care and support needs.

5. Portability of Services

5.1 The ability of disabled people to move and relocate is greatly reduced by the inability to move a care support package from one local authority to another. This issue of the “portability” of care is a huge barrier for disabled people living independent lives and accessing employment opportunities across a wider geographical area.

5.2 Currently, eligibility, and interpretations of eligibility, varies between local authorities, with many disabled people prevented and delayed from moving home because they cannot take their social care support with them. Scope therefore welcomes the Dilnot Commission’s recommendations for portable assessments and for consistent levels of care, set at a national level.

6. Local Authorities Budgets and the Ring-Fencing of Government Grants

6.1 It is extremely encouraging that the Government has allocated £2 billion a year of additional funding by 2014–15 to support social care through increasing grants to local authorities for social care by £1 billion in real terms by 2014–15, and setting aside £1 billion of the NHS budget by 2014–15 to fund new ways of providing services, including reablement and telecare services.
6.2 However, Scope have serious concerns that local councils are set to have their budgets cut by 7.1% every year for four years (approx. 28.4%), with the ring-fencing of all revenue grants also ending from 2011–12. The plans to phase out the ring-fencing of central Government grants to local authorities concern Scope greatly, as there is no guarantee that this funding will be spent on the care service provision for which it is intended.

6.3 Moreover, without proper controls and transparency with the Audit Commission set to be disbanded, there is even less assurance that grants will be spent on social care, and could be absorbed into local authority budgets. Therefore, Scope strongly recommends that the Government reinstate the ring fencing of Government grants.

7. THE CLOSURE OF THE INDEPENDENT LIVING FUND

7.1 The shortfall in funding for social care will be exacerbated by the imminent closure of the Independent Living Fund (ILF), which will be phased out by the next parliament. Currently, the Fund provides financial help with care packages so disabled people can remain in their community rather than enter residential care. The result of collapsing the fund will be that many disabled people who do not meet the new eligibility criteria will find themselves under-resourced and may be forced to move into residential care.

7.2 Scope would stress that the ILF provides a highly valued and effective service. Furthermore, the fact that the fund is both ring-fenced and operates on a basis of portability makes it a resilient source of support for disabled people.

7.3 Many disabled people use the ILF to provide social care services that are not provided by their local authority. Withdrawing the fund will have an extremely negative effect in maintaining the independence of disabled people. Scope are not persuaded that those who would have been eligible for ILF support will be able to receive the same support from their local authority, which already have a statutory responsibility to provide social care support to its residents and as part of this responsibility.

November 2011

Written evidence from University of East Anglia and London School of Economics (SC 79)

SUMMARY

1. Our evidence concerns differences in the care home fees faced by self-funders and those that Local Authorities (LAs) support. Evidence suggests that self-funders typically pay fees which are £50–£100 a week higher than fees paid by LAs for similar services. These differences may constitute induced “price discrimination” in the care home market resulting from LAs using buyer power to negotiate fees for the residents that they support, which are below care homes’ average costs per place. To break even and cover costs, care homes must charge all other residents a higher price. People who are no longer willing or able to afford a care home place in the private market but remain ineligible for local authority support—the “squeezed middle”—lose as a result.

2. Our research demonstrates that under the current means test there are enough self-funders for care homes to be able to recoup any losses on LA-funded residents via higher fees for self-funders as long as the discount to LAs is not too large. But reforms to the means test could change this.

3. Reforms of the care home means test which would increase the proportion of residents entitled to state help with their fees, would reduce care homes’ revenue if homes received the pre-reform LA fee for all post-reform LA-supported residents. For reforms where there would remain self-funders, care homes might therefore increase the fees for self-funders. Alternatively, LAs might have to increase the fees they pay to care homes for residents they support. For some kinds of reforms it might be possible for those who would be self-funders under the current means test, to continue to be liable for the self-funder rate, while receiving a non means-tested contribution from their LA.

4. We have examined the effects of alternative assumptions on what would happen to fees, on the public costs and the size and distribution by income level of gains from reforms which increase the proportion of residents entitled to LA support with their fees and so eligible for the LA fee. In such cases, if LA fees rise to maintain care homes’ income and the supply of places under a policy of free personal care this could increase the public cost by as much as 20% initially, and double it by 2027. Alternatively if residents who would otherwise be self-funders remain liable for the self-funder fee rate residents’ gains from the reform would be reduced by almost 30% on average.

5. The scale of this additional public costs or reductions in gains to residents is dependent on the reform examined. However we conclude that LA behaviour in negotiating care home fees needs to considered more fully in the debate on long-term care funding and especially when considering the costs and potential gains from funding reforms.
INTRODUCTION

6. Our evidence concerns differences in the care home fees faced by self-funders and those that Local Authorities (LAs) support. Of the issues that the Committee is considering, our evidence is relevant to the economic regulation of the social care system and implications of alternative funding regimes. It draws on research funded by the Economic and Social Research Council.247

7. LAs procure care home places for some two-thirds of older (65+) care home residents who pass a means test of their income and capital assets (Comas-Herrera et al., 2010). Evidence suggests that those excluded by the means test typically pay fees which are £50–£100 a week higher than fees paid by LAs for similar services (Laing and Buisson, 2011).

8. The care home market consists of a large number of relatively small private or not-for-profit providers. LAs, using their “buyer power”, may be able to procure assisted places from these providers at a price below the market rate. Low prices paid to care homes could force care homes out of the market resulting in a shortfall in capacity; and care homes might have to charge higher fees to self-funders to subsidise publicly-funded residents. Observed differences in self-funder and LA-supported fees may constitute induced “price discrimination” in the care home market.

EFFECTS OF DIFFERENCES IN FEES FOR LA-SUPPORTED AND SELF-FUNDING CARE HOME RESIDENTS

9. If the local authority negotiates a price which is below care homes’ average costs then, to break even and cover costs, the care home must charge all other users a higher price. The larger is the discount negotiated by the local authority, or the larger is the number of places procured by the local authority, the higher must be the private sector price for the care home to stay in business. People who are no longer willing or able to afford a care home place in the private market but remain ineligible for local authority support lose as a result. This is the “squeezed middle” who can afford the market (no price discrimination) price but not the higher private rate that care homes charge when local authorities exercise their buyer power. Other self-funders have to pay an inflated price to keep the care homes financially viable so also lose.

10. Our research (Hancock and Hviid, 2010) demonstrates that under the current means test there are enough self-funders for care homes to be able to recoup any losses on LA-funded residents via higher fees for self-funders as long as the discount to LAs is not too large. But reforms to the means test could change this. We found that the first round (unchanged demand) effects of a 6% LA discount on the market rate in residential care homes are that local authority costs would be about 8% lower than in the absence of price discrimination, costs met by user charges to local authority-funded residents would be lower by 3% but self-funders would pay 11% more.

11. One way to address concerns over those priced out of the market is for the local authority to include the squeezed middle by procuring places at the lower fee rate for all those who cannot afford the private fee rate. Including the squeezed middle does not cost local authorities anything directly because under the means test the squeezed middle are liable for the full fee rate negotiated by the local authority. But if the squeezed middle is large, such action may destabilise the market.

FEE DIFFERENTIALS AND REFORM OF THE FUNDING SYSTEM

12. Reforms of the care home means test which would increase the proportion of residents entitled to state help with their fees, would reduce care homes’ revenue if homes received the pre-reform LA fee for all post-reform LA-supported residents. For reforms where there would remain self-funders, care homes might therefore increase the fees they pay to care homes for residents they support. For some kinds of reforms it might be possible for those who would be self-funders under the current means test, to continue to be liable for the self-funder rate, while receiving a contribution from their LA. This is effectively what happened when Scotland introduced so-called free personal care.

13. Using two simulation models we have examined the effects of alternative assumptions on what would happen to fees, on the public costs and the size and distribution by income level of gains from certain reforms (Hancock et al under review). The reforms were:

(a) “free personal care”: a non means-tested subsidy, equivalent to the assumed care costs (as opposed to “hotel” costs) component of care home fees for all assessed as needing to be in a care home (similar to “free” personal care as implemented in Scotland);

(b) “limited liability”: a non means-tested subsidy as above after two years in a care home (proposed as an interim measure in the 2010 social care White Paper (HMG, 2010) and similar to the cap on costs proposed by the Dilnot Commission on Funding Care and Support (CFCS, 2011)); and

247 Through the ESRC Centre for Competition Policy (award number RES 578–28–0002), the Centre for Research on Micro-Social Change (award number RES 518–28–0001) and the Modelling Ageing Populations to 2030 programme (award number RES 339–25–0002). Material from the Family Resources and General Household surveys is crown copyright and made available by the Office for National Statistics via the UK Data Archive. All responsibility for the analysis and views expressed here rests with the authors.
(c) “housing disregard”: a disregard on housing wealth in the means test for the care component of care home fees.

14. All the reforms examined here would increase the proportion of residents receiving some LA support. If care homes were to receive the lower LA fee rate for all such residents, their income per resident would fall and the supply of care home places could reduce. We therefore examined three ways in which care home income per resident might be maintained after implementation of the reforms. One option is for the fee paid by LAs to rise. A second is for those who would be self-funders under the current system to continue to be liable for the self-funder fee. This is likely to be practicable only for reforms in which there is a non means-tested state contribution. The third option is for the self-funder fee rate to rise. This last option is clearly possible only for reforms where there remain some self-funders.

15. Working in April 2007 prices, we found that raising the LA fee rate would raise the public cost of the reforms by over £200 million (20%) for free personal care in 2007, and more than double that by 2027. For this reform it would reduce the average gain to care home residents by about £10 (10%) a week in 2007. Raising the self-funder rate has little effect on the public cost. Requiring residents who would self-fund under the current system to pay the self-funder rate under reforms where they would be eligible for a non means-tested state contribution reduces the average 2007 gains to care home residents by £13 (limited liability) and £26 (free personal care) or around 28% in both cases. If fee rates remain at their projected levels under the current system, the reforms would reduce the income per resident received by care homes by between £14 and £29 a week or 2.6% to 5.3% of their current average fee per resident.

16. The effects of the reforms and of the alternative assumptions on fee rates vary according to the residents’ income levels (Figures 1–3). Gains from free personal care increase steadily with income level, favouring most those in the highest income quintile. Without any fee adjustment, mean weekly gains in 2007 from free personal care range from £73 in the lowest income group to £175 in the highest group. Increased fee levels or maintaining self-funders on the self-funder fee rate reduces the gains most in the higher income quintiles but the association between size of gain and income level remains. The limited liability reform also benefits the highest income quintile most but there is less variation across the other income quintiles.

Figure 1

MEAN GAINS BY INCOME QUINTILE, FREE PERSONAL CARE AND PARTNERSHIP REFORMS, CARE HOME RESIDENTS AGED 85+, 2007

<table>
<thead>
<tr>
<th>Quintile</th>
<th>2007 Gains</th>
<th>2027 Gains</th>
</tr>
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<tbody>
<tr>
<td>Q1 (lowest)</td>
<td>73 65 52</td>
<td>78 70 56</td>
</tr>
<tr>
<td>Q2</td>
<td>76 69 55</td>
<td>97 88 70</td>
</tr>
<tr>
<td>Q3</td>
<td>97 88 70</td>
<td>175 156 129</td>
</tr>
<tr>
<td>Q4</td>
<td></td>
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<td>Q5 (highest)</td>
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17. In contrast to free personal care and limited liability, the housing disregard reform benefits those in the highest income group the least. Residents in this income group are likely to be able (and would be required) to meet their care home fees in full from their income. This is a reform that favours those who are housing rich but income poor. Indeed, if the self-funder fee rate rises to compensate for the increased proportion of residents paying the LA rate, residents in the top income quintile would lose an average of £66 per week from this reform in 2007.

**Figure 2**

*Mean gains by income quintile, limited liability reforms, care home residents aged 85+, 2007*

![Chart showing mean gains by income quintile](chart2.png)

18. It is commonly believed that LAs currently pay care home fee rates which are below the level at which care homes break even. If this is the case, the supply of care homes is dependent on care homes being able to charge self-funders higher rates to recoup losses on LA-supported residents. The form of the current means test facilitates this at least for modest LA fee discounts because it ensures sufficient numbers of self-funders are available to cross-subsidise LA supported residents.

19. A policy reform which substantially increases the proportion of residents on the lower LA fee may not be sustainable unless the LA fee rate is increased. If that happens, the cost of the reform to the public sector will be higher and the gains to care home residents will be lower. Alternatives to increasing the LA fee rate...
are either an increase in the self-funder rate or retaining the self-funder rate for those who would be self-funders under the present funding regime. While these have relatively small effects on the public finances, they can considerably reduce the benefits to residents that result from the reform. Indeed they can result in losses for some residents.

20. It would be unwise to ignore these issues when considering proposals to reform the long-term care financing system. We conclude that LA behaviour in negotiating care home fees needs to be considered more fully in the debate on long-term care financing.

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November 2011