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Written evidence submitted by Age UK (CB 01)

1. AGE UK

1.1. Age UK is the national charity and social enterprise working to transform later life in the UK. Our vision is of a world in which older people flourish. We aim to improve later life for everyone through our information and advice, services, products, training, research and campaigning.

1.2. Age UK is a member of the Care and Support Alliance and will be working closely with Alliance members seeking to improve the Bill on behalf of older and disabled people, those with long term conditions and their families. Over 70 organisations make up the Care and Support Alliance. We campaign together to keep adult care funding and reform on the political agenda.

2. INTRODUCTION

2.1. Age UK welcomes the Care Bill as an important step to reforming the social care system so it works well for older people. It modernises and consolidates the law and offers an ambitious and positive vision for the future of social care for current and future generations. If combined with sufficient funding — at present a very big ‘if’ — it guarantees an individual’s wellbeing and protects them from unreasonable costs.

2.2. Significant steps have already been taken in the House of Lords to improve the Bill but it could be strengthened further. We would particularly like to see the Bill further amended to:

i. Ensure that people who would currently be defined as having ‘moderate’ care needs are eligible to receive support. It is vital that the national eligibility criteria are set low enough to make a difference to people’s lives before they reach a ‘critical’ level of need.

ii. Improve safeguarding for people at risk of abuse and neglect, and improve access to redress mechanisms if their human rights are infringed, for example as a result of abuse.

iii. Ensure the cap on individual spending on social care is implemented fairly, based on a proper consideration of individual care needs and on eligibility criteria that are not unreasonably restrictive.

iv. Ensure the proposed national deferred payments scheme covers the full costs of living in residential care, making the scheme work as intended so that people do not have to sell their homes within their lifetime.

v. Make certain the assessment process is fair for everyone by ensuring local authorities do not unreasonably cut corners through the use of unqualified assessors or over reliance on digital, remote, assessment tools.

vi. Strengthen access to advocacy. The Bill has already been amended to give an individual the right to an advocate if they are ‘unbefriended’ but we believe that where there is family disagreement on the best type of care or a low level of understanding of the assessment process, there should be a right to request an advocate.

3. UNDERSTANDING THE SOCIAL CARE FUNDING GAP

3.1. The current and future funding of adult social care is likely to be ‘the elephant in the room’ throughout the remaining stages of this Bill. Social care funding has declined by £1.2 billion in real terms since May 2010. At the same time the population of over 85s, the cohort most likely to need social care, continues to rise and councils are facing a demographic pressure of around 3 per cent of adult social care budgets per year. In the Spending Review earlier this year the Government announced the creation of an ‘Integration Transformation Fund’ of £3.8 billion which, in time, should certainly benefit social care to some degree. However, LGA modelling (July 2013) shows that a combination of funding cuts and spending pressure is creating a social care funding gap in local government that is growing at around £2.1 billion a year. On current trends, by the end of the decade the gap will total around £14.4 billion they say.

3.2. The combination of these factors mean the vision of the Bill cannot possibly be realised unless the funding shortfall is addressed.

4. AMENDMENTS

4.1. Ensure people with ‘moderate’ care needs are eligible to receive support

4.1.1 What is the problem?

Today, access to publicly funded social care is more restricted than ever. In 85% local authority areas, it is only available if your needs are assessed as being ‘substantial’ or ‘critical’. Many older people who need help getting up in the morning, bathing, preparing meals or doing the shopping are assessed as only having ‘low’ or ‘moderate’ needs. If the new national eligibility threshold for care is set at the equivalent of ‘substantial’, as has been suggested, this will mean anyone assessed as having moderate or low needs will not qualify for help, shutting all these people out of the system — until their needs become much worse.
4.1.2 Why does it matter for older people and their families?

Because of rationing there were 250,000 fewer people aged 65 and over in receipt of care and support in 2012/13 compared to 2007/08. This reduction is definitely not due to lower demand, indeed, as has been explained, demand is rising. When accounting for demographic changes during the same period almost half a million older and disabled people who would have been eligible for care and support five years ago are no longer able to access these services.

Community based services like lunch clubs and fitness classes — a lifeline especially for those living on their own — or services providing respite for carers have also been cut back, with the numbers of older people they help declining from 958,000 in 2009/10 to 802,000 in 2011/12. Unless they can afford to pay privately for services, or have family and friends able to help, it is likely that the older people affected will go without support altogether. This year we estimate that the number of people with unmet care and support needs stands at more than 800,000.

4.1.3 How could it be resolved?

The new eligibility threshold needs to be set by regulations at a fair minimum level. For Age UK that must mean ‘moderate’ or its equivalent in the new system.

The Bill could also be strengthened by requiring that regulations link eligibility for social care to the achievement of outcomes based on the individual’s wellbeing, as defined in the Bill. Amending the legislation in this way would ensure that commissioners would be required to consider how to help someone achieve all aspects of wellbeing set out in the Bill.

Making sure that local authorities plan sufficiently to meet the diverse needs of their population and promote quality and choice in services already forms part of the Care Bill. These provisions could be strengthened by requiring service commissioners to monitor the sufficiency of social care provision in their area, and to take action if this is inadequate when compared to local demand, including demand from self-funders. Similarly Clause 8 of the Bill — which describes the kinds of support which local authorities must offer — should be extended to make clear that support does not just mean ‘traditional’ social care services, but should also include crucial components like transport.

4.2. Improving Safeguarding

4.2.1 What is the problem?

For the first time in England the Care Bill will include legislative measures to protect adults from abuse. (Scotland already has legislation to protect adults from abuse and Wales is in the process of developing some.) This is an important step forward in better protecting older people from risk in England but we need to ensure that the legislative framework protects them in all social care settings.

Despite the new safeguarding provisions we are not all equally protected regardless of where we receive social care services. This is because the Human Rights Act may or may not apply to an individual, depending on how their care is funded. Those who self-fund or receive home care services from a private organisation under contract from a local authority are not currently covered by the Human Rights Act 1998, while those receiving local authority funded care are. Age UK believes this is iniquitous and the amendment made in the House of Lords to the Bill should be supported in the Commons.

4.2.2 Why does it matter for older people and their families?

People who use social care services may receive intimate care, be moved from place to place or have diminished mental capacity. In all these situations and in many more they are potentially vulnerable to neglect and abuse. Regardless of how their care is funded the law should protect them against the risk of harm. For two people in the same social care setting to be entitled to different levels of legal protection, depending on how their care is funded, makes no practical sense. Moreover, the only realistic way of creating a culture of adult safeguarding is to ensure the same rights apply to everyone in receipt of care, across all settings.

4.2.3 How could it be resolved?

We believe the scope of the Care Bill should be extended by broadening the definition of adults at risk of abuse to those who ‘may have’ needs for care and support, rather than only those who ‘have needs for care and support’. The current Bill includes people who have needs which are not being met by the local authority, but not people who are isolated from care services and who as a result may never have been assessed as having care and support needs.

The Bill’s scrutiny committee recommended that corporate responsibility for abuse should be borne by the care provider as well as by an individual who commits acts of abuse. Age UK agrees and believes this recommendation should be accepted by the Government.

The Government should use the Care Bill to accept Lords’ amendments and close the existing loopholes, meaning people who are vulnerable to having their rights infringed are all within the scope of the Human Rights Act, with an equal right to redress.
The Bill also includes powers for local authorities to delegate the carrying out of statutory functions such as assessment to independent sector agencies. It must be made clear that in this situation such agencies are also subject to the Human Rights Act.

In responding to the Department’s separate consultation about whether additional powers of entry are needed where abuse or neglect of an adult is suspected, Age UK has argued that these powers are required where a third party is denying access to the person. While we do not expect new powers to be in the Bill itself we would like the Bill to make provisions to enable and require the Secretary of State to issue regulations.

4.3. Ensure that the cap on individual spending on social care is implemented fairly

4.3.1 What is the problem?

About three quarters of us will need some care as we get older, but while about half of us can expect to pay out about £20,000, 1 in 10 people will spend over £100,000. The cost can even run to hundreds of thousands of pounds for an unlucky few.

It is widely recognised that we need to protect people from the risk of catastrophically high costs and ensure everyone can plan to meet the cost of care in a fair and sustainable way.

Age UK was therefore very pleased when the Government announced that it had decided to implement the Dilnot proposals, but disappointed that they opted for a £72,000 limit on costs — considerably higher than the level recommended in Andrew Dilnot’s report. When considering these figures it is important to recognise that they do not apply to all the costs of living in residential care; an individual would still have to pay up to £12,000 a year on bed and board to meet these expenses for example, even once their care costs had reached the £72,000 limit. We would like the Government to reduce the limit over time.

4.3.2 Why does it matter for older people and their families?

The Government estimates that once it has implemented its version of the Dilnot proposals about 1 in 6 of all the older people who need care, or about 100,000 individuals, will benefit to at least some extent from them by 2025. However, most older people will still have to pay something towards their care, and many will have to pay a lot. Only those people with less than £14,250 in savings and really serious care needs will get their care free.

A few months ago the Government published a consultation paper explaining how it intends to implement the Dilnot proposals. Unfortunately, Age UK’s view is that there is considerable ‘devil in the detail’, and that many older people and their families will be surprised and disappointed that the small print restricts both the amount of help given, and the numbers of older people who are able to take advantage of it.

4.3.3 How could it be resolved?

The Care Bill contains paving clauses allowing the Government to introduce regulations setting out the level of the cap on social care costs and the higher means test threshold which is another element of its version of the Dilnot reforms. During the passage of the Bill we would like to see the Government being open about the timetable.

We also believe that a commitment to implement a national deferred payments scheme should be included on the face of the Bill and that this scheme should be available to anyone who reasonably wants to take advantage of it. This would mean that someone would not need to sell their home to pay for care within their lifetime and could instead defer the payment of care costs until their estate was being settled following their death.

The Bill must also be clear on what is included in the deferred payment system. The amount people are be entitled to defer must be sufficient to cover the full costs of living in residential care. This should include fees, which may substantially exceed the local authority’s ‘usual rate’; living expenses, which are likely to be substantially higher than the level of the currently inadequate Personal Expenses Allowance; interest on the deferred payment; and the costs of maintaining the property.

4.4. Top-ups and charges

4.4.1 What is the problem?

At present older people who found to be eligible for care by local authorities and who go into a care home are charged under national rules. However, it is often a source of surprise to them and their families when they find that additional payments over and above these charges in the form of ‘top ups’ are often demanded from a third party, usually a relative. The legislation that enables local authorities to request such top ups, the ‘Choice of Accommodation Directive’, is intended to enable the person to choose a care home that is more expensive than the local authority would normally pay for, given the person’s needs. However this system is widely abused with local authorities citing ‘usual rates’ that bear little relation to the market price of care or being reluctant to increase their ‘usual rate’ where the person has particular needs which increase the cost of their care. As a result, over a quarter of care home residents pay top up fees.
4.4.2 *Why does it matter for older people and their families?*

In the future the problem of top-ups will affect people who expect their expenditure to count towards the spending cap that the Bill introduces. Spending towards the cap is assessed at the rate that the local authority says it would pay to meet those needs. If this rate is unrealistically low the person will have to spend more than this. Even if the local authority is realistic about its ‘usual rate’ individuals might not be able to obtain care at the same cost as they cannot negotiate bulk rates in the way that the local authority does. We are therefore concerned that individuals will have to spend a great deal more than £72,000 before they reach the £72,000 cap.

Older people who are carers may be particularly affected as charges may wipe out a substantial part of a household’s income and assets, with the result that a carer may face long term impoverishment.

4.4.3 *How could it be resolved?*

As the Bill stands Clause 30 does nothing to deal with this unacceptable situation. It should require that the local authority takes account of actual market conditions in setting its ‘usual rate’; make clear that the amount the local authority agrees to pay must be varied if it is necessary to meet the individual’s assessed needs; and say that a third party top up cannot be required unless these two conditions have been met. Charges should also be limited to what is ‘reasonably practical’ for the person to pay.

Furthermore, Clause 28 currently states that an ‘independent personal budget’ sets out what the cost would be to the local authority to meet a person’s eligible needs. This should take into account the fact that the economies of scale councils enjoy from ‘bulk buying’ care means this will be less than an individual may pay. As well as preventing abuse in the use of top-ups, it would also present a fair representation of what an individual has spent towards reaching their care cost cap. Expenditure towards the cap should therefore be calculated on the basis of what the person spends, not what it would cost the local authority.

4.5. *Ensure the assessment process is fair for everyone*

4.5.1 *What is the problem?*

The assessment process is the gateway that everyone who wishes to access care and support must pass through in order to have their needs met. However the Bill is intended to ensure that following assessment, even people who do not qualify for local authority support will receive some help to meet their own care needs, including advice and information. The spending cap assessment will also determine whether a person’s spending on care will count towards the cap.

The assessment process is therefore more important than ever and without a clearer legislative framework governing how this process will operate there are fears that councils could use unqualified assessors or make inappropriate use of digital, remote, assessment tools in order to cut costs.

4.5.2 *Why does it matter for older people and their families?*

Getting a fair assessment of needs is vital to ensuring that those needs are adequately met. We know that older people often under-report their problems and it can take a skilled professional to uncover the true picture. Only then will the right care package be put in place. Conversely, an inappropriate assessment process could wrongly filter people out of the care system when they should be receiving support.

The Bill has been amended in the House of Lords to improve this process. Compared to the initial draft Bill there is a clear separation between assessment of need and subsequent consideration of how needs should be met, as recommended by the Law Commission. This is particularly important in ensuring that needs which are being met by a carer — and therefore the carers’ contributions — are recognised and valued. The Bill has been strengthened, with requirements to involve appropriately skilled professionals where necessary but there is still room for improvement.

4.5.3 *How could it be resolved?*

It is important that the Bill ensures that the initial assessment is sufficiently skilled to ensure that no one falls through the net. Some people might prefer to assess their own needs. This should be possible but the local authority should still have to ensure that they have enough information to properly consider the person’s needs, which might mean asking some more detailed questions.

Regulations issued under the Bill must set out a clear assessment process that ensures that the needs of individuals are properly considered. The Bill requires that the Secretary of State should issue regulations but we would like to see clearer commitments about what they will contain.

4.6. *Strengthen access to advocacy*

4.6.1 *What is the problem?*

Some people need support to communicate their views and experiences clearly and if they do not receive this from an independent advocate they may not be able to articulate what they want or need from the
social care system. Advocacy helps voices to be heard and enables people to stay in control of their lives. But currently the provision of advocacy remains patchy so whether you are properly involved in important decisions about your life can depend on where you live.

4.6.2 Why does it matter for older people and their families?

Independent advocates provide intensive support, especially to people who find it hard to express their views and needs, or to make decisions about their care. They ensure that people won’t have to face the intimidating and complex process of assessment alone. This helps to makes sure they get the care they need when they need it.

Age UK and the Care and Support Alliance have welcomed a Government decision to guarantee that tens of thousands of people each year who would struggle to navigate the social care system alone can turn to an independent advocate. We have been campaigning for a right to advocacy since the Bill was introduced to Parliament in draft form last year.

However, the right to an advocate will only apply to those who are ‘unbefriended’ — which means that people who have family or friends but who still need this specialist support won’t be able to access it. Sometimes families disagree about the right care. In these circumstances ensuring an individual can access advocacy is really important.

4.6.3 How could it be resolved?

We would like to see a right to advocacy or other appropriate support if someone needs this to be able to participate in the assessment process. This might not only apply to people who have no friends or relatives to assist them. The Bill should be amended to secure this right in law.

REFERENCES


2 Age UK, Agenda for Later Life 2013, p.88


4 ibid

5 ibid

6 Commission on Funding of Care and Support, Final Report

7 Care Bill — Social Care Funding Reform Impact Assessment, p.10

January 2014

Written evidence submitted by Macmillan Cancer Support (CB 02)

1. INTRODUCTION

Macmillan Cancer Support welcomes the Care Bill as a crucial opportunity to improve the lives of people selflessly providing unpaid care to loved ones with cancer. We warmly welcome the Government’s ambition to create a system in which everyone can get the care they need when they need it. However, there are currently significant gaps in the identification of carers which must be addressed by the Committee for this ambition to be realised.

2. EXECUTIVE SUMMARY

— There are approximately 905,000 carers of people with cancer in England, half of whom are not receiving any support despite it having a substantial impact on their lives.

— Carers of people with cancer come into contact mostly with health professionals, who are not sufficiently identifying them, meaning only 5% receive a carers’ assessment.

— The Care Bill places a duty on local authorities to provide services and in doing so identify carers with unmet needs, which we warmly support. However, the duty does not extend to health bodies, meaning carers will continue to slip through the net.
3. IDENTIFICATION AND SIGNPOSTING TO SUPPORT AND INFORMATION FOR CARERS

Care Bill legislation should specify that local authorities must work with health bodies in order to adequately identify carers with unmet needs and provide sufficient services and support for them.

There are close to a million people in England selflessly providing unpaid care to family and friends with cancer. These carers are making a major contribution to society through improving patients’ quality of life and saving health and social care services nearly £12.1 billion per year. Yet nearly half of carers of people with cancer are not receiving any support in return for giving on average almost 15 hours of care each week. As the number of cancer patients is set to double from two to four million by 2030, so too will the number of carers. We must capitalise on this opportunity to improve the lives of carers now before the Bill is passed and the Government’s agenda moves on.

Unmet needs

The support carers of people with cancer provide has a substantial negative impact on their lives. Nearly half say it affects their mental health and wellbeing. One in five say it affects their relationships and working life and 15% say it affects their household finances. Almost half of carers of people with cancer identify at least one type of support they are not currently receiving that would help them and their household finances. They are in real need of help but are not aware of who or where to turn to for support.

Patrick, who cared for his wife Pam with cancer:

“I felt very isolated and vulnerable, increasingly so as Pam’s illness progressed. I remember reminding myself that compared to what Pam had to deal with, my needs were secondary and I had to focus on meeting her needs, despite often feeling ill-equipped and unsure. I ended up being admitted to hospital with a severely inflamed gall bladder, probably brought on by stress according to the doctor. I feel very strongly that people looking after someone with cancer need more support. I think politicians need to be aware of the central role carers play.”

Why are carers of people with cancer not receiving support?

Three in five people providing unpaid care to loved ones with cancer do not consider themselves to be a ‘carer’. They therefore lack awareness of carers’ rights, such as the local authority carers’ assessment, which is the gateway to statutory support. It is therefore of little surprise that only one in three carers of people with cancer have heard of a carers’ assessment and only 5% have actually had one. This is estimated to be lower than the proportion of all carers looking after people with other conditions and disabilities.

Of the very small number of carers of people with cancer who have had an assessment, the event that most often prompted this was a referral by a GP. A 2013 Carers Week survey of over 2,000 carers found that over 70% of carers come into contact with health professionals (including GPs, doctors and nursing staff) during their journey. Yet health professionals only identify one in ten carers and GPs only identify 7%. Carers UK also reported this as an issue in their State of Caring 2013 report where they found that ‘67% of carers said their GP is aware of their caring responsibilities but gives them no extra help’.

Chantal Simon, Medical Director for Professional Development, Royal College of GPs: “GPs are currently only paid for supporting carers through their obligation to provide general medical services to all their registered patients. Although most GPs are very sympathetic to the needs of carers and appreciate the work that they do, many GPs do not consider support of carers to be their job. Practices are cutting back on medical services that they have always offered because of their income squeeze. There is a need for a national framework or guidance on how the NHS can better identify and support carers.”

4. THE CARE BILL

We are extremely pleased that the Care Bill enhances rights for carers, including placing a new duty on local authorities to undertake a carers’ assessment for all carers. We are also pleased that local authorities must have regard to the importance of identifying carers in their populations with unmet needs with the aim of early intervention and prevention of future needs under clause 2.

1 Estimated annual economic value based on the estimated number of cancer carers in England and data on the number of hours of unpaid care they provide each week, multiplied by a unit cost for replacement care. Estimated number of cancer carers in England and data on the number of hours of unpaid care provided taken from Macmillan Cancer Support and Ipsos MORI research conducted in 2011. Unit cost of £18 an hour for replacement care is based on 2011 NHS Information Centre data. This estimate follows the same method as the 2011 Carers UK/University of Leeds paper which estimated the annual economic value of all UK carers at £119 billion.


3 Carers Week (2013) Prepared to Care? Exploring the impact of caring on people’s lives

4 Carers UK (2013) State of Caring
Yet at present there is no sufficient, explicit requirement on health bodies to do the same. As outlined above, carers of people with cancer are mainly seen in health settings and are less likely to have contact with local authorities. It is therefore unlikely that local authorities will be able to identify the 47% of carers of people with cancer in their populations with unmet needs unless they work closely with health bodies through forums such as health and wellbeing boards. Given the cross-party recognition that more integration between health and social care is essential, we are surprised clause 2 does not mention the NHS. The cooperation clause 6 states that health bodies must ‘co-operate’ with councils in the exercise of their ‘respective functions relating to carers’. However this does not go far enough as neither the Care Bill nor the Health and Social Care Act sets out the NHS’s function in identifying carers. It is therefore highly likely this responsibility will remain on local authorities and the NHS will have to do very little, if anything, to ‘co-operate’ to identify carers with unmet needs.

It is encouraging that there are a number of Department of Health initiatives to provide additional support for carers within the NHS, and health professional groups such as the RCGP is working on CCG best practice guidance for supporting carers. However a range of relevant bodies must have procedures and systems in place to identify carers with unmet needs while allowing local authorities to take a lead on this. In practice this would include the national roll out of these DH-funded initiatives which have already proved effective in promoting carer identification in healthcare settings.

James Drummond, Lead Officer for Integrated Services, Torbay and Southern Devon Health and Care NHS Trust

“We know carers don’t always recognise themselves as a carer and can remain ‘hidden’ from services and miss out on support because of this. In Torbay we understand that a ‘whole system’ approach is needed to support carers and that proactive identification is needed by the NHS. If we wait for carers to approach us we may not engage until there is a crisis. Proactive identification is good practice, but national support is needed to spread this across the country. It should be made clear that identifying carers and signposting them to support is the responsibility of all health and social care professionals, not just local authorities.”

Carers UK, Carers Trust and a cross-party group of MPs supported this call in the Social Care (Local Sufficiency) and Identification of Carers Private Members’ Bill 2012/13, highlighting the range of support for a requirement on health bodies to identify carers and ensure they receive appropriate information and advice. Indeed, the Government called for the same thing in its Care and Support White Paper. It outlined their requirement for, “NHS organisations to work with their local authority partners... to agree plans and budgets for identifying and supporting carers”.

5. How have Scotland and Wales tackled this issue?

Both the Welsh and Scottish Governments have recognised the seriousness of this challenge and have taken steps to address it in legislation with statutory requirements on Local Health Boards (LHBs) to lead on published strategies outlining how they intend to identify and support carers. This has led to initiatives such as the West Wales Hywel Dda Health Board’s work with GPs to roll out an ‘Investors in Carers’ programme. In addition, LHBs across Wales have been undertaking Carer Awareness training with frontline staff.

Keith Bowen, Director, Carers Wales

“The Carers Strategies Measure (Wales) 2010 has provided an important impetus to the carers’ agenda in Wales. It has acted as a valuable catalyst to constructive work across Wales, led by LHBs, to identify carers and target relevant information to them. It has also helped galvanise efforts to increase awareness of carers’ issues via training for frontline professionals. It is early days but initial indications are that the Measure has helped improve joint working at a local and national level.”

In Scotland, each LHB has developed a Carer Information Strategy to identify and provide information and support to carers. NHS Education Scotland and the Scottish Social Services Council are working together with partners to develop core values, skills and knowledge to help staff across the whole health and social care workforce to work with carers. Reports from LHBs outline success including increased referrals to support by NHS staff, and improved ‘carer awareness’.

6. What we are calling for and why

Care Bill legislation should specify that local authorities need to work with health bodies in order to adequately identify carers with unmet needs and provide sufficient services for them. We believe that this could be achieved through one of the following options:

— Clause 2, part 2(c) is strengthened to include a line on the importance of working with health bodies in carrying out this specific function.

6 Carers Week (2013) Prepared to Care? Exploring the impact of caring on people’s lives
— A new line is inserted below clause 2, part 2(c) which says: “(d) the importance of working with health bodies in carrying out these functions.”
— The Care Bill brings about an amendment to the Health and Social Care Act placing an equivalent requirement on health bodies to have regard to the importance of identifying carers with unmet needs in their area.
— Regulations or statutory guidance states the importance of working with health bodies on identifying carers with unmet needs through forums such as health and wellbeing boards.

We will be working with MPs to table amendments and working with Officials on regulations and guidance to achieve this. Only then will:
— Identification take place in every local authority and health area across England and not in patches as is currently the case.
— Carers be identified as early on in their journey as possible when, in many cases, they just need signposting to appropriate information, help and advice, or existing support centres. This will then achieve clause 2’s ultimate aim of preventing needs further down the line when they are in need of more intensive support and resource from the NHS and local authorities. This in turn has the potential to save money.
— Health bodies have effective procedures and systems in place to identify carers with unmet needs while allowing local authorities to take a lead on this. In practice this would mean the roll out across England of DH-funded initiatives which have already proved effective in promoting carer identification8.

January 2014

Written evidence submitted by Imogen Parry (CB 03)

THE CASE FOR INCLUDING HOUSING AS A STATUTORY MEMBER OF SAFEGUARDING ADULTS BOARDS

From: Imogen Parry, Independent Safeguarding Adults Consultant, Researcher and Trainer for the Housing Sector

1 INTRODUCTION

My background includes: social work, social policy lecturing, older people’s housing policy, chairing a national charity promoting sheltered housing (erosh) and publishing 6 good practice guides on sheltered housing.

I currently specialise in adult safeguarding research, consultancy and training and have just completed the MA in Safeguarding Adults: Law, Policy and Practice at Keele University. I have published eight articles this year on housing and safeguarding (Parry, 2013 a-h) and spoken at several conferences on the subject.

My MA dissertation on ‘Adult Serious Case Reviews: lessons for housing providers’ (for which I was awarded a distinction, and which is due to be published, abridged, next year in the Journal of Social Welfare and Family Law) provides much of the evidence base for this submission, along with the outcome of my survey this year of Independent Chairs of Safeguarding Adults Boards (SABs) regarding the extent and benefits of housing representation on SABs. My research has contributed to the forthcoming Department of Health commissioned Social Care Institute for Excellence (SCIE) guide on housing and safeguarding.

2 SUMMARY

This submission supports the case for the inclusion of a new Clause in the Care Bill requiring housing representation on SABs. It argues that this would:
— encourage greater leadership and involvement by housing staff in adult safeguarding
— improve the quality of Serious Case Reviews/Safeguarding Adults Reviews
— contribute to wider agendas including prevention and awareness raising, domestic abuse, crime, hate crime, self-neglect, hoarding, anti-social behaviour, poverty
— reach into local communities, address professional boundaries, reinforce that safeguarding is everyone’s business, contribute funding, involve housing in the development of policy
— improve joint working between housing and adult social care.

The submission suggests solutions to the problem of achieving housing representation in two tier authorities.

8 CIRCLE, University of Leeds (2011), New Approaches to Supporting Carers’ Health and Wellbeing: Evidence from the National Carers’ Strategy Demonstrator Sites Programme, p62
3 Joint Committee on the Draft Care and Support Bill

I submitted written evidence to the pre-legislative scrutiny committee of the Care and Support Bill (Joint Committee on the Draft Care and Support Bill, 2013, p. 103), recommending that housing should be added to several clauses, including to: the list of partners (Clause 4 — Co-operating generally); the list of statutory members of SABs (Clause 35, Schedule 1).

That committee accepted both of these recommendations, quoting my evidence on partners (Joint Committee on the Draft Care and Support Bill, 2013, paras.118, 119, p. 33) and SABs (para.163, p. 42).

4 Care Bill

The Government rejected these (and several other) recommendations about housing in its response (Department of Health, 2013). However, during the subsequent passage of the Care Bill through the House of Lords, clauses about housing as partners were successfully introduced as amendments (Clause 6 (3) (d); Clause 6 (4) (b)). However, the recommendation that housing should be included in the list of statutory members of SABs was not pursued. This submission focuses on the case for reconsidering this.

5 The Government’s case for the rejection of housing representation on SABs

The Government stated in their response to the recommendations of the Joint Committee on the draft Care and Support Bill that ‘We have intentionally restricted core statutory membership to a few core public bodies, leaving local areas with maximum flexibility whilst securing the statutory position of adult safeguarding. We anticipate and expect membership to be far wider. We would be most concerned if SABs did not address the role, contribution and responsibilities of housing providers in adult safeguarding. We would also expect SABs to draw on the housing sector for in-put, collaboration and advice. Government will not dictate how this happens, as this will depend on local circumstances, which vary widely across the country. For example, in some areas the SAB may operate sub-groups, including one devoted to housing-related issues that reports back to the main Board’ (Department of Health, 2013, p.67).

6 The case for the inclusion of housing representation on SABs

There are several arguments to be made for the inclusion of housing representation on SABs:

6.1 To encourage the engagement of housing in adult safeguarding

I have written elsewhere (Parry, 2014, forthcoming) that ‘had the recommendations on the inclusion of housing on SABs been accepted (by Government), they would have been the most likely to increase the involvement of housing providers in adult safeguarding in general, and in improving the quality of housing related Serious Case Reviews in particular’.

I consider that the inclusion of housing on SABs would help to encourage housing providers to take safeguarding more seriously, in the absence of other legislative and regulatory requirements on housing providers to engage in safeguarding (Parry, 2013a, p.16). Housing providers currently under-report abuse, largely due to lack of staff training on signs and indicators which is due to lack of strategic leadership by senior housing managers. I have argued elsewhere that less than one in a hundred cases of abuse are referred by housing staff into social services adult safeguarding procedures (Storr, 2013a,b).

Up to a half of tenants of general needs social housing are vulnerable, yet most staff training has been focused on those working only with tenants living in sheltered and supported housing (Parry, 2013a, p.16). Half of all the murdered, abused and neglected individuals who were the subjects of the housing-related SCRs studied for my dissertation lived in general needs housing, the other half lived in sheltered and supported housing (Parry, 2014, forthcoming).

Serious case reviews have indicated that housing providers could or should have played a more effective role in adult safeguarding. My dissertation research concluded that housing providers should improve:

— data bases of all tenants ensuring that vulnerabilities are identified
— support and contract monitoring involving vulnerable tenants
— awareness of safeguarding by all staff and ensure effective reporting of abuse (Parry, 2014, forthcoming).

There is growing recognition that all front-line housing staff are ideally placed to prevent, detect and report abuse. Evidence of increased Government recognition of the potential of all housing staff is demonstrated by the Department of Health commissioning:

— PASAUUK to run a workshop on housing and safeguarding (PASAUK, 2013))
— Social Care Institute for Excellence to produce a guide on housing and safeguarding (SCIE, 2014, forthcoming).
6.2 Improve the quality of Serious Case Reviews (SCRs)

My dissertation research on published housing related SCRs (Parry, 2014, forthcoming) commented on the poor quality of 8 of the 21 SCRs studied. The defects included:

- inadequate detail on the role or actions of housing providers
- a lack of awareness of the Quality Assessment Framework requirements under the Supporting People programme
- a disconnection between the findings and the recommendations for housing
- no reference to how the implementation of recommendations would be monitored.

I suggest therefore that the presence of housing representation on SABs would ensure that housing representation on any SCR (to be replaced by Safeguarding Adults Review) panels would be likely to prevent these deficiencies in the future.

6.3 Other perceived benefits of housing representation on SABs — evidence from current Independent Chairs of SABS

In April this year, I surveyed, via email, all 63 independent Chairs of SABs and received responses from 17 individuals who chair 26 SABs. All but two of these 26 SABs had housing representation on the Board. The Independent Chairs stated that the benefits of housing representation on their SABs included:

- Contribution to wider agendas including: prevention and awareness raising, domestic abuse, crime, hate crime, self-neglect, hoarding, anti-social behaviour, poverty
- Reaching into local communities
- Addressing professional boundaries, reinforces that safeguarding is everyone’s business
- Engaging with Serious Case Reviews
- Contributing funding
- Involving housing in the development of policy, practice, improvement plans. (PASAUK, 2013).

6.4 Improve joint working between housing and adult social care

My dissertation research on housing related SCRs found that housing providers are inhibited in their effectiveness in adult safeguarding due to:

- Barriers to information sharing, often caused by negative attitudes towards housing staff.
- High referral thresholds by adult social care.

The presence of housing providers on SABs could help to address these barriers at a senior and strategic level.

7 Overcoming difficulties in the two tier authorities

One argument put forward to support the case against housing representation on SABs is that, particularly in the two tier authorities, it is too difficult to secure district council representation (there could be up to 10 such councils) and housing association representation (there could be dozens). I consider that this is not sufficient reason to abandon the goal of housing representation on all SABs. My own advice to SAB chairs and others regarding this issue is: secure one committed senior district council rep who can speak for all of them in the county AND secure one committed senior housing association rep who can ‘represent’ (in the loosest sense) housing associations across the county — find this person through existing cross county housing forums of chief officers; ensure good channels of communication between these representatives and those they are representing.

8 Conclusion

‘The role of housing in preventing and addressing adult abuse is neglected in legislation, policy, practice and research’ (Joint Committee on the Draft Care and Support Bill, 2013, para.163, p.42, quoting my written evidence to that committee).

The inclusion in the Care Bill of a Clause requiring housing representation on SABs would address not only the first of these neglected areas (legislation) but would also improve policy and practice. The change argued for in this submission would have a lasting, symbolic and significant impact on the protection and safeguarding of adults at risk and I urge the Committee to consider the arguments made.

References

The Care Bill [HL] Bill 123. Published 31.10.2013. As brought from the Lords.


January 2013

Written evidence submitted by United for All Ages (CB 04)

1. Will the cap make the care system easier and simpler? No. It will make the current complex care system even more complicated — with two caps, a confusing means test, new eligibility criteria, qualifying care and multiple assessments.

2. Will the cap prevent older people having to sell their homes? No. The £72,000 proposed cap is on qualifying care costs only — in addition older people living in care homes would face large bills for the so-called ‘hotel’ costs eg food, accommodation, daily living expenses, plus any top-ups for care costs that exceed the local authority standard rate. An older person would probably have to live in a care home for five years before reaching the cap (the average stay is just over a year). So older people could be faced with bills of £200,000 plus and still have to sell their home — either while alive or after death to refund a deferred payment.

3. Will the cap meet growing unmet need? No. The plans do not bring extra cash into the care system — they substitute private spending by some (mainly wealthy) individuals with public spending — and they will do nothing to promote better quality care through better training, pay and conditions for staff. The cap will
not meet current unmet needs (almost one million older people are not getting the support they need) let alone growing demands of our ageing population in the future.

4. Will the cap promote prevention and support the integration of care and health? No. It will not promote prevention — it is all about how crisis care, mainly towards the end of life, should be funded. We need a fundamental shift towards ageing well as well as better care for those who need it. The cap will not promote integration of care and health and community initiatives to support older people at home and prevent high level needs. It will create a new separate funding stream mainly to pay for expensive residential care.

5. Will the cap benefit those struggling to pay for care and help older people and their families on low-mid incomes? No. The cap is primarily about protecting the inheritances of wealthier families while impoverishing older people with low/mid value homes. The plans will leave many more older people struggling on their own, relying on family carers or using their own resources to pay for care. Even poorer older people with assets less than £118,000 will find that the tapered means test requires them to make substantial contributions towards their care costs.

With care in crisis, this Bill is not going to tackle the shortfall in care funding and the growing unmet needs facing our ageing population.

January 2014

Written evidence submitted by Inclusion London (CB 05)

(1.0) 1. INTRODUCTION
(1.1) Inclusion London would be grateful if the Scrutiny Committee would consider the proposed amendments suggested in this document and recommend them to the House of Commons. The amendments can be found in from paragraph (4.0) in Part 4. of this paper.

(1.2) Inclusion London
Inclusion London is a London-wide organisation, run by and for Deaf and disabled people, which promotes equality for Deaf and disabled people in London and provides capacity-building support for Deaf and disabled people’s organisations in the capital.

(1.3) Disabled People
There are:
— 11.5 million people in the UK who are covered by the disability provisions set out in the Equality Act, this is 19% of the population.
— Approximately 1.4 million disabled people are living in London.
— Just under 1.3 million disabled people aged 16 to 64 years resident in the London.

(2.0) 2. INCLUSION LONDON’S GENERAL PRINCIPLES REGARDING INDEPENDENT LIVING/SOCIAL CARE

(2.1) What is independent living and why we need this duty alongside a well-being duty
Independent living for disabled people means having the same opportunities, choices and rights as other citizens. It’s about being able to get a job, build a career, have an education and take part in community and public life. Independent living is about being able to choose when to go bed, when to get up, what to eat. It’s about having the chance to be a parent and friend, have a family and social life. It’s about being able to live in your own home with people you choose to live with and being able to leave that home to get out and about — go shopping, go to see a film, meet up with friends. Independent living is about being able to contribute, participate and be included.

(2.2) The current ‘well-being’ definition in the Care Bill 2013 does incorporate some aspects of independent living, but it leaves out vital independent living concepts of choice, access, inclusion, rights and equal participation. We need independent living and these concepts explicitly included in the Care Bill to ensure the full and equal participation of disabled people as much as the well-being of the individual. Independent living works and has been directly responsible for the development of key social care policies including personalization and Direct Payments.

10 http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106
(2.3) Independent living is at the heart of the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which was ratified by the UK in 2009\textsuperscript{12}. Choice is a key aspect of Article 19\textsuperscript{13} of the UNCRPD as it gives the State the responsibility to ensure that disabled people have ‘choices equal to others’ and to ensure that disabled people have a right to choose where and with whom they live. An explicit duty to promote independent living will ensure that the Care Bill 2013 reflects and expresses the UNCRPD.

(2.4) Independent living as a goal and a right is not just applicable to disabled people of working age but all care and support users.

(3.0) 3. Funding crisis

(3.1) Funding for Care and Support is at crisis point. Research by the London School of Economics for Scope revealed that there is £1.2 billion funding gap for social care support for disabled people under the age of 65\textsuperscript{14}, also Age UK’s Care in Crisis 2012 report\textsuperscript{15} showed that there is a shortfall of £500 million a year just to maintain the inadequate levels of care and support for older people as provided when the Coalition government was elected.

(3.2) Local authorities in England have reduced adult social care budgets by £1.89 billion during the period from April 2011 to March 2013 — this is at a time when the numbers of older and disabled adults continues to grow at 3 per cent per year\textsuperscript{16}. As a result social care/independent living support in many areas is at a minimal level so support is only provided to get up, dress, eat and go back to bed. This basic level of support isolates and excludes disabled people and prevents ‘inclusion in the community’, breaching Article 19 of the UN Convention.

(3.3) The government has now set the national eligibility criteria at substantial\textsuperscript{17} needs under the Fair Access to Care Services (FACS). As a result ‘105,000 disabled people are at risk of not getting the basic support they need to help them eat, get washed and leave their homes if Government sets eligibility at ‘substantial needs’\textsuperscript{18}.

(3.0) The under-funding of social care/independent living support does not make economic sense as without this support many disabled people will not be able to work, volunteer or live an active life and as a result are more likely to see their needs escalate and in turn call on expensive health services\textsuperscript{19}.

(3.4) Fair and sustainable funding

Inclusion London believes that social care and independent living support should be free for all at the point of delivery, paid for by national insurance contributions/general taxation similar to the funding mechanism for the NHS, this would be a fair and sustainable funding system.

(4.0) 4. Inclusion London’s recommendations for key amendments to the Care Bill 2013:

(4.1) Inclusion London urges the Scrutiny Committee to support the proposed amendments to the Care Bill 2013 as detailed below to secure and enable disabled and older people’s independent living, choice and control.

(4.2) The first suggested amendment would place disabled people and older peoples independent living at the heart of the Bill:

1. Amendment to: Clause 1 Promoting individual well-being\textsuperscript{20}
   Each proposed amendment is highlighted in \textbf{bold}:

   1 Promoting individual well-being and \textbf{independent living}

   (1) The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual’s well-being, \textbf{independence and inclusion as equal and valued citizens and members of the community}.

   (a) \textbf{That duties under independent living promote the wider definition of independent living as expressed in the UN Convention on the Rights of Persons with Disabilities.}

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\textsuperscript{12} http://www.un.org/disabilities/default.asp?id=259
\textsuperscript{13} See relevant part of ‘Article 19 — Living independently and being included in the community’ below:
   ‘States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:
   a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;’.

\textsuperscript{14} Please see Article 19 in full in Appendix 2

\textsuperscript{15} http://www.scope.org.uk/news/other-care-crisis
\textsuperscript{16} http://www.adass.org.uk/index.php?option=com_content&view=article&id=813:a
\textsuperscript{17} http://www.nationalhealthexecutive.com/Integrated-care-Social-care/Lamb-sets-national-eligibility-criteria-for-social-care
\textsuperscript{18} http://www.bps.org.uk/news/unemployment-can-lead-depression
\textsuperscript{20} http://www.publications.parliament.uk/pa/bills/chill/2013-2014/0123/chill_2013-20140123_en_2.htm#pt1-pb1-l1g1
(2) “Well-being”, and “independent living” in relation to an individual, means that individual’s well-being and independence so far as relating to any of the following—

(a) personal dignity (including treatment of the individual with respect); respect for privacy and individual autonomy;
(b) physical and mental health and emotional well-being;
(c) protection from abuse and neglect;
(d) control and choice by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
(e) full and equal access to, and participation in, work, education, training, volunteering, recreation, cultural, public and community life;
(f) social and economic well-being;
(g) domestic, family and personal relationships;
(h) suitability and choice of living accommodation;
(i) the individual’s contribution, participation and inclusion as equal and valued citizens to society.

(3) In exercising a function under this Part in the case of an individual, a local authority must have regard to the following matters in particular—

(a) the importance of beginning with the assumption that the individual is best-placed to judge the individual’s well-being and independent living needs;
(b) the individual’s views, wishes, feelings and beliefs;
(c) the importance of preventing or delaying the development of needs for care and support or needs for support and the importance of reducing needs of either kind that already exist;
(d) the need to ensure that decisions about the individual are made having regard to the individual rights as a disabled person under the UNCRPD; all the individual’s circumstances (and are not based only on the individual’s age or appearance or any condition of the individual’s or aspect of the individual’s behaviour which might lead others to make unjustified assumptions about the individual’s well-being)
(e) the importance of the individual participating as fully as possible in decisions relating to the exercise of the function concerned and being provided with the information and support necessary to enable the individual to participate;
(f) the importance of achieving a balance between the individual’s well-being and that of any friends or relatives who are involved in caring for the individual; but the needs of carers should not be used to obstruct disabled people’s active participation in society;
(g) the need to protect people from abuse and neglect;
(h) the need to ensure that any restriction on the individual’s rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary for achieving the purpose for which the function is being exercised.

(4.2) 2. Amendment to Clause 2 ‘Preventing need for care and support’

The best way to support independent living and well-being is through the provision of high quality, community based services, which meet the needs of disabled and older people with ‘low’ level needs.

Inclusion London asks the Committee to recommend an amendment so there is a duty to:

— Maintain independent living and well-being through the provision of preventative, personalised community based services that enable people to have choice, control and independence.

(5.0) 3. Independent Living Fund

Amendment to insert a new clause

(5.1) There are very serious concerns that if the Government decides to continue with the plan to close the Independent Living Fund (ILF) in 2015 users’ care and support will be dramatically reduced to the basic ‘clean and feed’ level currently provided by Local Authorities. We believe that the ILF is a model of good practice that should be extended and developed rather than being dismantled.

(5.2) There are no provisions in the Care Bill to ensure disabled people’s independent living after the proposed closure of ILF in 2015.

(5.3) We ask the Committee to propose that a new Clause is added to the Bill to ensure that:

— The cost effective and very successful Independent Living Fund (ILF) is kept open and reopened to those eligible before the closure to new applicants in 2010.
— Set up an Independent living task force, co-produced with ILF users and disabled peoples organisations, to review independent living including the Independent Living Fund, in order to

identify how best to improve, develop and extend independent living support so that is fit for the
21 century, as recommended by the Joint Human Rights Committee report of November 2012.

(6.0) 4. Advocacy

(6.1) It is crucial that independent advocacy is provided right through the process of obtaining and
maintaining a disabled person’s care and support.

(6.1) Independent advocacy will enable disabled people to participate in the assessment and review process
but also enable disabled people to give direct feedback about the quality of services, which will help prevent
ongoing abuse of disabled people in the future.

(6.2) Therefore we ask the Committee to recommend the following amendments in bold to three clauses:

Clause 5. Promoting diversity and quality in provision of service

(2) In performing that duty, a local authority must have regard to the following matters in particular—

(c) the need to offer and provide an independent advocate to enable service user feedback to
improve the quality of services

(The subsequent parts of this clause will need to amended, so the original (c) become (d) and the original (d)
because (e) etc).

Clause 9. Assessment of adults need for care and support

(5) A local authority, in carrying out a needs assessment, has

(d) A duty to offer and provide an independent advocate to the adult to enable full participation in
all needs assessments and reviews

Clause 42. Enquiry by local authority

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it
to decide whether any action should be taken in the adult’s case (whether under this Part or otherwise) and, if
so, what and by whom. The local authority must—

(a) Offer and provide an independent advocate to an adult who is experiencing, or at risk of, abuse
or neglect to enable them to give evidence and participate fully in the enquiry.

(7.0) 5. Amendment to Clause 9 ‘Assessment of an adult’s needs for care and support’

(7.1) The assessment is the key gateway to care and support so it is important that disabled people who are
expert in their own needs should be at the core of the assessment process.

(7.2) Inclusion London urges that the Committee propose an amendment to ensure that:

— All care assessments reflect the rights to independent living and choice encompassed in the
UNCRPD. Also that all assessments are a person centred process.

(7.3) Other people, including carers, should not be invited to an assessment unless the adult being assessed
agrees.

(7.4) Therefore we recommend that Clause 9 is amended to (amendments are in bold):

(5) A local authority, in carrying out a needs assessment, must involve—

(a) the adult,

(b) any carer that the adult has asked to be involved.

(8.0) 6. Amendment to Clause 13 ‘The eligibility criteria’

(8.1) In June 2013 the government announced a new national eligibility threshold for care and support,
which will be introduced in 2015 ‘at a level equivalent to ‘substantial’ in current guidance’.

(8.2) However, LSE research, published in January 2013 revealed that ‘105,000 disabled people are at risk
of not getting the basic support they need to help them eat, get washed and leave their homes if Government
sets eligibility at ‘substantial needs’.

(8.3) Inclusion London asks the Committee to put forward an amendment to ensure that:

— The eligibility threshold for care is set at a ‘moderate’ level to ensure that disabled people are
able to receive the support needed in order to live independently.

(9.0) 7. Amendment to Clause 18 ‘Duty to meet needs for care and support’

(9.1) Many disabled people prefer the services provided by the voluntary sector such as local Deaf and disabled people’s organisations (DDPOs) with an expertise in disabled people’s needs. These organisations find it difficult to compete against bids from large organisations. Commissioners need to recognise the added value which DDPOs can bring to the provision of care services.

(9.2) Inclusion London asks the Committee to propose an amendment to Clause 18 Duty to meet needs for care and support (the amendments are in bold).

(5) A local authority, having made a determination under section 13(1), must meet the adult’s needs for care and support which meet the eligibility criteria if—

(a) the adult is ordinarily resident in the authority’s area or is present in its area but of no settled residence, and

(b) the adult’s accrued costs exceed the cap on care costs,

(c) **A duty for Commissioners to take into account the added value local Deaf and disabled people’s organisations bring to delivering independent living support services, and weight tenders accordingly.**

(10.0) 8. Amendment to Clause 31 ‘Adults with capacity to request direct payments’

(10.1) It is important for disabled people that the current duty for local authorities to offer a direct payment remains in place. So we ask the Committee to propose the amendments in bold below:

**Adults with capacity to request direct payments**

(1) The local authority must offer the adult a direct payment

(2) This section applies where—

(a) a personal budget for an adult specifies an amount which the local authority must pay towards the cost of meeting the needs to which the personal budget relates,

(b) the adult requests the local authority to meet some or all of those needs by making payments to the adult or a person nominated by the adult, or

(c) **the adult accepts the offer of a direct payment.**

(11.0) 8. Amendment to ‘Continuity of care and support when an adult moves’ — Clause 37 ‘Notification, assessment etc’

(11.1) Disabled people should have the same freedom to move home as non-disabled people i.e. without the fear that their care and support package will be removed or reduced.

(11.2) Inclusion London urges the Committee to propose an amendment below (see wording in bold):

Clause 37. Notification, assessment, etc

— **The new care package provided by the second authority must be equivalent to the existing care package, provided by the first authority.**

(12.0) 9. Conclusion

(12.1) Inclusion London would be grateful if the Scrutiny Committee could propose the amendments to the Care Bill 2013 above, to ensure that disabled people’s rights to independent living, choice and control is placed at the heart of this vital legislation.

January 2014

Appendix 1

LINKS TO CLAUSES

(The numbers refer to the Clauses in the Care Bill 2013):

Clause 1. Promoting individual well-being:


Clause 2. Preventing needs for care and support:


Clauses regarding the provision of independent advocacy:

Clause 5. Promoting diversity and quality in provision of services:

Clause 9. Assessment of an adult’s needs for care and support

Clause 42. Enquiry by local authority

Clause 9. Assessment of an adult’s needs for care and support

Clause 13. The eligibility criteria:

Clause 18 Duty to meet needs for care and support

Clause 31. Adults with capacity to request direct payments

Clause 37. Notification, assessment, etc

Appendix 2

UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

Article 19 — Living independently and being included in the community

States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

(b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

Written evidence submitted by Marie Curie and Help the Hospices (CB 06)

Since the Draft Care and Support Bill was published, Marie Curie and Help the Hospices have been calling for the legislation to provide for fast-track access to local authority-funded social care for terminally ill people and their carers. We have been doing this because we know that most terminally ill people and their carers will face waits of up to 30 days to get access to social care. Some will die while waiting. Research also shows that people who have access to social care are far less likely to use hospital care and therefore to die in hospital

than those who do not. With the majority of people in England and Wales still dying in hospital (49.65%)\textsuperscript{34}, it is vital that we make local-authority funded social care more accessible to those who are terminally ill and their carers.

We welcomed the Government’s amendment to the Bill which made clear that local authorities can treat the needs of terminally ill people as urgent. However, we feel that this clause should be strengthened so that local authorities will treat the care needs of terminally ill people as urgent. Currently, severe inequity exists around access to services for terminally ill people, with those living in affluent areas and being White British far more likely to die at home than those who live in less affluent areas\textsuperscript{35} and those from black, Asian, minority and ethnic (BAME) groups struggling to access the care they need\textsuperscript{36}. We are concerned that the Bill will deepen this inequity as some local authorities will treat the care needs of terminally ill people as urgent and others will not. This runs counter to the core principle of the Bill, which is to make high quality care available to all, regardless of where they live or their personal circumstances.

We are also concerned that local authorities are not prompted to consider the needs of people who care for someone who is terminally ill as urgent. When someone who is terminally ill has an informal carer they are far more likely to die at home\textsuperscript{37}. Where the carers of terminally ill people are unsupported, the person they are caring for is more likely to suffer an emergency admission to hospital, which drastically increases their chances of dying there. We call for the Bill to be amended so that Subsection 4 of Clause 19 is worded as follows:

\begin{quote}
A local authority \textit{should} meet an adult’s needs and their primary carer’s needs under subsection (3) where, for example, the adult is terminally ill (within the meaning given in section 82(4) of the Welfare Reform Act 2012).
\end{quote}

Both Help the Hospices and Marie Curie recognise the Care Bill as a landmark piece of legislation that will go a long way towards ensuring that everybody who needs care gets the right level of support that they need. Care for terminally ill people needs to be addressed properly in the Bill because death and dying are issues that everyone will experience. The number of people dying each year is increasing, and people are now more likely to have complex health and social care needs at the end of life. Too often we hear stories of terminally ill people and their carers for whom care is either simply not available or for whom it arrives too slowly to make a real difference. The Care Bill offers the opportunity to correct this situation and we ask that you and your fellow Committee Members amend the Bill to ensure that all terminally ill people and their carers can get the care and support they so desperately need.

\textit{January 2014}

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\textbf{Written evidence submitted by Tim Kendall (CB 07)}

Returning to the Care Bill and further to the second reading, I have concern over some of the wording of the section on ‘Independent Advocacy’.

Section 68) subsection 4) requires a local authority to make a judgement about an individual or carers ability to communicate their wishes. This may be perfectly appropriate where an individual is clearly lacking capacity, as the criteria in Section 68) 4) a)-d) are drafted similarly to the formal capacity test set out in the Mental Capacity Act code of practice. However, in the case of an individual with capacity or a carer, performing capacity tests and in effect making a best interest decision before making a referral to an independent advocate it is not appropriate or ethical.

I believe that this no-doubt unintended consequence of the Care Bill’s current drafting can be rectified with an inclusion in section 68) of a clause similar to an IMHA referral in the Mental Health Act. ie ; (in layman’s terms) ‘prior to a meeting under the provisions laid out in section 68) sub section 3) a)–i), an individual or carer, unless previously identified by professionals as lacking capacity, shall be provided with both written and oral information regarding their right to an independent advocate and the role of an advocate. Individuals and carers may refer themselves to the local Advocacy service identified, or ask to be referred.’

The same applies to section 68) subsection 5). It is not primarily for the local authority to decide that an individual has someone ‘appropriate’ to support them. Again the individual or carer needs to be informed in advance about the role of an independent advocate and right to access one as they may prefer to use their support, above a friend or relative, given the choice.

The same principle applies to section 69).

\textsuperscript{34} Office for National Statistics. \textit{Deaths registered in England and Wales}. 2013.


\textsuperscript{36} National End of Life Care Intelligence Network. \textit{Variations in Place of Death in England, Inequalities or appropriate consequences of age, gender and cause of death?}


\textit{Understanding place of death for patients with non-malignant conditions}. 2012.
I hope my submission might ensure the Bill really provides effective advocacy support for individuals and carers, as intended.

January 2014

Written evidence submitted by Hampshire Law Society (CB 08)

CARE BILL 2013 SUBMISSION

This submission is sent on behalf of Hampshire Law Society, which represents 600 solicitors in Hampshire. We invite the committee of the House of Commons to consider these comments when it is reviewing the Care Bill 2013.

Our submission relates to the amendment which was proposed, but then withdrawn, by Lord Dubs while the bill was before the Lords (Ref 104ZE) The proposed amendment would have been placed after clause 66.

There have been a number of proposals that the bill should include measures to establish a tribunal which would ensure that the care regime was enforceable. Both the Law Commission and the Parliamentary Select Committee which provided pre-legislative scrutiny advocated such a tribunal. Lord Dubs, the architect of the Chronically Sick and Disabled Persons’ Act 1970, tabled an appropriate amendment. The Government response (as set out in Hansard of 29th July) was that it is reviewing the local authority complaints system, notably through its consultation on implementing Funding Reform, and that it might introduce an appropriate amendment to the Care Bill once the findings of the consultation were known.

The consultation referred to above closed in October 2013. The government has failed to indicate when the analysis of the consultation results would be completed. It appears that the government misled Lord Dubs when it indicated that it was open-minded as to a possible amendment of the bill, because it has subsequently failed to ensure that the consultation was analysed in time for its conclusions to be considered and if appropriate an amendment be tabled.

THE UNDERLYING PROBLEM WHICH AN APPROPRIATE AMENDMENT MIGHT RESOLVE

1. The Care Bill as presented to the House does not include any measures by which its provisions might be enforced by an aggrieved individual.

2. Community Care Law is extremely complex. It is very hard for legal professionals, let alone service users, to understand the rights and obligations of the many agencies involved. Even when the Care Bill is enacted this area of law will remain baffling to many practitioners.

3. The high cost of legal services has meant that the only source of independent advice for many service users are not-for-profit advice agencies.

4. Many disputes involve disputes of fact.

5. The present means of resolving disputes are:

   — Local Authority and NHS Complaints procedures. These are slow and generally paper based, so that often the complainant never feels that his complaint has been properly addressed. If the complainant is not sufficiently articulate on paper he will be placed at a disadvantage.

   — Ombudsmen. The same criticisms apply, and in addition the complainant is at the mercy of the case worker, who may not necessarily appreciate the complex issues involved.

   — Judicial Review. In practice this remedy is only open to those complainants who have such limited means that they are entitled to public funding. Only a few solicitors have the necessary Legal Services Commission contracts. And the process does not resolve disputes of fact. With LSC funding to be reduced from April 2013, Judicial Review, which is a very expensive activity, is likely to become less frequently available.

6. The result is a massive pool of people who feel that their grievance has not been resolved, and that bad practice will not be checked.

OUR SUBMISSION

We submit that the committee should call for evidence from the Government as to the consultation referred to above regarding the local authority complaints procedure and ensure that an appropriate amendment is tabled and considered.

January 2014

Written evidence submitted by The College of Social Work (CB 09)

STAGE BRIEFING

The College of Social Work (TCSW) is the centre of excellence for social work and provides resources to its members to uphold and strengthen standards of professional practice. It holds the professional standards
for social work, supports the professional development of social workers, and campaigns on issues relating to social work policy and practice. An independent membership organisation, The College provides quality assurance for initial and post-qualifying education through its training and education endorsement scheme.

The College is led by and accountable to its members, and as such this response was produced in conjunction with members of its Adults Faculty and policy champions volunteers.

Like colleges for other professions, our role is to:
- Hold the standards for the profession and support and enable our members to meet those standards.
- Be the voice of the profession to policy makers and the media, ensuring that our members speak up for the profession.
- Be led by and accountable to our members — the profession. We do this in order to improve the outcomes for the people served by our profession.

Wellbeing and Prevention and the Future of Social Work

Late last year TCSW published a discussion paper, the Business Case for Social Work with Adults38, which sought to demonstrate the unique contribution social workers made to the lives of service users. We argued that in order to meet the agenda put forward by the Government, social work with adults, carers and families would have to reinvent itself and not rely upon the old verities of care management. TCSW made clear that local authority styles of social work must evolve from a paternalistic relationship with a caseload of ‘clients’ into a partnership with service users who aspire to be ‘active citizens.’

Over the past few years social workers have learnt to work on the basis of co-production, blending professional understanding with the knowledge of an individual’s own situation, preferences, networks and neighbourhood. The incorporation of personalisation and diversity into policy and practice better encompasses the highly complex circumstances many individuals are faced with, a point that is reflected in the Care Bill’s wide ranging approach to wellbeing.

This desire for change has been seized upon by the sector both on the frontline and at the strategic level. The President of ADASS Sandie Keene, writing in the report, The New Social Care: Strength Based Approaches, stated that “old-style social care saw people with problems. Today, we see people with potential, hopes and aspirations,” before adding that the “the days of local authorities being paternal and risk averse are gone.”39

While we agree that this person-centred approach is being steadily disseminated in policy and practice across the sector, it would be premature to declare that the risk averse, paternal approach to social care is over. Current systems are still strongly influenced and dominated by task orientated approaches, with care assessments viewed as a means of gathering evidence to inform what services an individual might require.

It therefore remains the case, particularly where resources are tight, for social work practice to focus upon case activities that are centred on essential tasks. This emphasis, which can be seen as a consequence of local authorities reverting to their statutory duties in the face of budgetary pressures, does raise questions as to how well poised councils are to implement the proposals outlined in the wellbeing and prevention clauses. Huge systemic challenges lie separate the Government’s aspirations from reality. TCSW is concerned that local authorities are not resourced to deliver a well-being and preventative agenda.

The current financial climate may be a considerable obstacle to successful system change. Local authority social care budgets have shrunk by £2.68bn over the last three years, while the Chancellor has outlined a further overall 10 per cent to be cut from budgets in 2015/16. London Councils have warned that the costs of implementing the new funding proposals under the care cap could leave the capital’s borough with costs of up to £1.14bn — equivalent to half the current annual cost of London’s adult social care. The rapidly rising cost of social care has also been documented by the LGA, with the body estimating that spending on care will pass 45 per cent of council budgets by 2019/20.40 Significant shifts are already occurring. Last year the spend on social care made up around a third of the total council budget. This has risen to 41 per cent in 2013/14.

At the same time, the average current spend on prevention of £588m in 2013/14 only makes up 4.2 per cent of the total social care budget. However, as the LGA warned in their adult social care spending round submission, reducing spending on prevention and early intervention is one of the only places left to look for further savings.41 A ComRes poll of councillors for the British Red Cross revealed that local authority cuts to preventative care are leaving elderly and vulnerable people at risk, with nearly two thirds of elected members admitting that their local authority had cut or frozen funding for preventative and lower-level social care since the last local election. Cuts to preventative services are averaging around 16 per cent. Sixty-nine per cent of councillors who’ve experienced cuts said that people in need will not receive the care they need.42

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40 http://www.local.gov.uk/media-releases/-/journal_content/56/10180/3624637/NEWS
41 http://www.local.gov.uk/media-releases/-/journal_content/56/10180/3624637/NEWS
42 http://www.comres.co.uk/poll/806/british-red-cross-social-care-survey.htm
WELLBEING AND PREVENTION AND THE NATIONAL ELIGIBILITY THRESHOLD

Underpinned by the wellbeing principle, the Bill proposes a complete makeover of the care system. The language used by the Government suggests that services will no longer be barred to all but the most vulnerable and desperate, and rightly discredits the current model in favour of one which mobilises the resources of communities to support people well before they reach crisis point. The Government has indicated that it wants to build a system that promotes independence and reduces dependency.

TCSW was therefore disappointed when in June the Chancellor George Osborne announced that the national minimum eligibility threshold would be set at a level equivalent to ‘substantial’ under the current guidance framework. TCSW had argued that ‘moderate’ would allow for local authorities to better respond to the needs and wants of individuals seeking care and support. TCSW would argue that setting the threshold at the substantial band could fatally undermine this intent. While we acknowledge that the resources required to support the individuals with support needs at this level form the bulk of social care spending, it is only allocated to those whose needs are greatest, and who represent only a relatively small subset of people with care needs. TCSW contends that such an offer is unlikely to reduce dependency and promote independence.

However, it became apparent when gathering responses from social workers in anticipation of this response that even arguing for a ‘moderate’ national threshold would not go far enough. There is a view among a significant number of social workers, many of whom will have already experienced several major reforms of social services during their careers, that the care system is fundamentally flawed. While there is widespread support for a Bill that looks to put into legislation the principles of wellbeing and prevention, there are serious reservations regarding the capacity of a system that is intrinsically built around managing deficits to meet these aims.

This in turn raises a bigger question regarding the course the Government should take. While TCSW acknowledges that the regulations set out in the discussion document should be understood in the context of the wider Care Bill, we are concerned that they offer more of the same in terms of focussing on care activities that are centred on essential tasks. Past evidence would suggest that this approach will never be able to fully address the full circumstances of a person’s life.

While social work assessments are supposed to focus on needs, the reality is that need is usually interpreted in the light of available resources. While in principle the two are distinct, practice can be very different. Strategic decisions can have a huge impact on the services available to individuals.

Social work assessments, coupled with people’s own self-assessments, should determine the nature and extent of the care packages that people receive. In reality, though, the principal determinant is too often the availability of resources. These resource allocations are often based on historical costs of meeting a certain group of needs. As explained below, this fails to acknowledge that:

— The growth of personalisation has resulted in more varied approaches to meeting need altered the associated costs;
— There is no straightforward correlation between a given level of need and the cost of meeting it, at least if the varied nature of people’s needs and choices are properly taken into account;
— That the cost and availability of services varies from one area to another only compounds this issue further. Resources that may be appropriate to respond to the needs of an individual in one area may be insufficient in another. As such two individuals with identical needs living in two different parts of the country may be receiving profoundly different services. The Government’s proposals do little to alter this fact.

WHAT THE GOVERNMENT NEEDS TO CONSIDER

TCSW is urging the Government to radically consider the scope and purpose of this consultation. As we have demonstrated, local authorities facing severe financial pressures are likely to cut services that matter most to delivering the care and support agenda outlined in the Care Bill. We have seen instances in the past where progressive agendas have been submerged by financial realities. TCSW is fearful that the situation here will be no different.

We would argue that the Government:

— strongly reconsider the merits of a national minimum eligibility threshold that continues to focus on deficits;
— consider an approach to prioritising needs to enable consistency of response across the country without compromising the uniqueness of each person;
— consider how assessment and resource allocation can be properly separated, leading to care and support planning that meets all needs as necessary to deliver independence and wellbeing.

January 2014
Written evidence submitted by David Hawker (CB 10)

I am writing to inform you about a problem with local authority policies on medication handling in social care. I am aware that medication handling is not currently addressed within the Care Bill. I would like to suggest that you consider including brief legislation in the Bill to clarify Parliament’s position.

The problem is that, at present, it appears that carers in England are often not permitted to help disabled clients take non-prescribed medicines of their choosing.

This problem came to my attention because my mother has been receiving personal care in her own home, in Leicestershire, for several years. As well as taking prescribed medicines, she uses several substances which her GP cannot prescribe, such as herbal medicine, creams and tinctures, and dietary supplements. Her GP has no objection to any of these substances and has confirmed that my mother has full mental capacity to use them. But because of her physical disability, she cannot take some of the substances without assistance.

In September last year, my mother’s care provider decided that carers may not assist her with non-prescribed medicines in any way. Social Care has confirmed that the provider’s decision was consistent with Leicestershire County Council’s policy. They see it as following from the Care Quality Commission’s guidance (specifically The Health & Social Care Act 2008 Regulations 2010, Regulation 13), though I cannot see that their view is supported by medical opinion or written policy, or by the regulation they cite. I understand that many care providers and other local authorities agree with Leicestershire’s position. The reasons for the view seem to be driven by fear of carers being held responsible for harming service users, even those who have full mental capacity, and who therefore hold full responsibility for the choices they make.

I am concerned that care providers are not supporting their clients to make their own decisions about treatment. Providers’ refusal to assist mentally competent service users in their choices seems like an attack on personal freedom, as well as a failure of person-centred care, service integration, and disability support.

This is not a unique issue affecting one person, one provider, or one local authority that we could effectively address through local authority or ombudsman complaints procedures. Rather, it seems to be a common view among local authorities that paid carers should never help their clients use non-prescribed medicines, even when medical practitioners do not object and the service user has full mental capacity. Does the Care Bill Committee share that view? If not, it appears that local authorities are lacking guidance to form sensible policy in this area. Will you include legislation in the Care Bill to clarify Parliament’s view?

January 2014

Written Evidence Submitted by the Equity Release Council (CB 11)

OVERVIEW AND SUMMARY

— This briefing has been prepared by the Equity Release Council for the Public Bill Committee scrutinising the Care Bill. The briefing note covers the background to equity release and the Equity Release Council as well as the two areas of concern — the role of financial advice, and the universal deferred payments scheme.

— It is set out in the context of equity release products being a potential funding option for individuals to use when paying for their own care.

— The Council is keen to ensure that individuals facing the financial cost of social care are able to do so with the support of a wide range of financial products, including equity release, in a competitive market. Given the complexity of social care funding, the Council is keen for individuals to have the support of expert regulated financial information and advice, and hopes that Parliament and the Government will recognise these concerns.

BACKGROUND TO EQUITY RELEASE AND THE EQUITY RELEASE COUNCIL

1. Equity release allows individuals aged 55 and over to release money from the property they live in without having to make any monthly repayments. Providers of both of the two types of equity release — lifetime mortgages and home reversion plans — are regulated by the Financial Services Authority, and give home owners the ability to draw a lump sum or regular smaller sums from the value of their home, while remaining in their home. Equity release can be and is used for a range of purposes, including funding of social care.

2. The Equity Release Council is the industry body for the equity release sector. Born from an expansion of the remit of SHIP (formerly Safe Home Income Plans), the Equity Release Council represents the providers, qualified financial advisors, lawyers, intermediaries and surveyors who work in the equity release sector. It currently has just under 300 members, and represents 90% of the sector.

3. The Equity Release Council is keen for policymakers to consider equity release as one of a range of options in funding retirement, including funding social care. The Council has been engaged in this issue since the draft Care Bill was first published, having submitted evidence to the Joint Committee on the Draft Care and Support Bill and to the Department of Health’s consultation on the practicalities of the reform, and through the Lords stages of the Care Bill.
4. The Council is generally strongly supportive of the Government’s proposed reforms to care. Our members welcome the policy intention behind the Bill of establishing a single framework for care and support as well as the creation of a ‘cap’ on social care funding.

5. **Financial planning for one’s retirement** — including taking maximum advantage of one’s assets and state benefits — is a complex area, shown by the constant coverage not just in the personal finance columns of the press but also front page stories which discuss and debate entitlements to the state pension, how to purchase the best annuity, and of course how to pay for social care.

**Paying for care & regulated financial advice**

6. The Government’s reforms include two welcome changes that help protect individuals of all backgrounds. The first is the proposed increase in the asset threshold for means-testing to £118,000 from £23,250, which will help many more individuals pay quite significant sums of money. The second is the principle of the cap on the adult social care costs any individual must pay. However, it is important that people understand what the cap will cover and what it will not.

7. Many individuals will still have to pay quite considerable sums of money. Providing care is expensive and will continue to be expensive. In light of this, we welcome the financial certainty that the reforms give individuals which help them more reliably plan for their retirement. Equity release can be one of a range of options individuals can consider in paying for care in their own home (domiciliary care).

8. Clause 4 of the Bill requires local authorities to provide an information and advice service for social care, including relating to the finances of care. The Council welcomes the presence of this clause but believes it should be strengthened given the complexities of care funding.

9. The Equity Release Council’s position is that those who are likely to commence paying substantial sums of money for their care should be encouraged /facilitated towards independent expert financial advice.

10. This should be given by a qualified adviser regulated by the Financial Conduct Authority, who has an appropriate accreditation in giving advice on older people’s issues (such as the CF8 qualification from the Chartered Insurance Institute or the Later Life Adviser Accreditation awarded by the Society of Later Life Advisers).

11. Independent regulated financial advisers are fully trained to give advice on a range of issues and products and are able to answer complex questions which relate to care funding. They are best placed to understand the needs of individuals after considering all the aspects of that person’s life, including assets, income, expenditure, and family needs.

12. It should be noted that existing services such as the Money Advice Service and the Citizens Advice Bureau do not have sufficient capacity or expertise to provide the advice needed — and cannot be expected to replace the role of independent financial advisers who are able to advise people on products to help fund their care needs.

13. During the House of Lords stages of the Bill, the Council briefed peers on the importance of regulated financial advice. While the Government has already sought to strengthen the independence of financial advice in the Bill, and has made a number of welcome commitments at the dispatch box in the House of Lords, the Council continues to believe that regulated and qualified independent financial advice is in the interest of the person with the social care need.

14. The Council is still concerned that the Government has not yet recognised the need for financial advice to come from people properly qualified to give it. Peers have warned of the consequences of a lack of regulation, and we agree that the Government still needs to reflect further on this before ruling out the idea of some regulation on care-related financial advice.

**The universal deferred payment scheme**

15. The Government’s reforms propose the creation of a universal deferred payment scheme (clauses 34-36), aimed at ensuring that people do not have to sell their home in their lifetime to pay for residential care.

16. Deferred payment schemes are complex financial arrangements with long-term consequences, which would have the same effect on the owner and their estate as equity release products such as a lifetime mortgage.

17. The Financial Conduct Authority’s rules are that giving advice on equity release products is a regulated activity, in light of the complexity and impact of the products.

18. The Equity Release Council goes further than FCA rules, and has established standards which require that providers of equity release products must take reasonable steps to ensure that:

— there has been a full discussion as to the implications of the plans for the customer and their family and that the customer was made fully aware of such implications;
18. The Council’s safeguards have evolved due to many years of experience in dealing with equity release customers and it continues to change — for example, in late September an additional requirement was introduced, requiring advisers to present every customer with a suitability report to clearly show the reasons why a particular product has been recommended for their personal needs.

20. The Council has put these safeguards in place to protect and safeguard consumers, who may be at a difficult time in their life and who are not used to dealing with such significant sums of money. The safeguards also ensure that customers benefit from the skills, training and diligence of the professionals involved.

21. For the same reason, the Council believes that people must have independent regulated financial advice before taking out a deferred payment arrangement.

22. There have been substantial discussions on the universal deferred payments scheme during the House of Lords stages, between Labour peer Lord Lipsey (a member of the former Royal Commission on long term care, and a member of the Equity Release Council’s advisory board), and the Minister, Earl Howe.

23. The Government has made welcome comments on the Council’s concerns. In particular, Earl Howe agreed that it was not enough for local authorities to hand out information leaflets and that they needed instead to take proactive measures to ensure individuals received tailored advice. He also said that the Government has recognised the need for sound independent advice.

24. However, the Council believes there are still concerns that need to be addressed. The first is to ensure that the same level of safeguards and protections for customers of equity release products are also in place for those who take out deferred payment arrangements.

25. The Council also wishes the Government to give a stronger commitment to ensuring that individuals only enter into deferred payment arrangements because they are the most appropriate for their individual circumstances, and to ensure that staff who end up providing advice on deferred payment arrangements recognise the complexity of the arrangements, and do not end up providing incorrect or misleading advice.

26. Finally, the Council is sympathetic with the argument of the Local Government Association that there should be a single national deferred payment scheme, rather than having each single local authority run their own scheme.

CONCLUSION

27. The Council is keen to ensure that individuals facing the financial cost of social care are able to do so with the support of a wide range of financial products, including equity release, in a competitive market. Given the complexity of social care funding, the Council is keen for individuals to have the support of expert financial information and advice, and hopes that the Public Bill Committee will recognise these concerns.

January 2014

Written evidence submitted by Northumberland County Council (CB 12)

CARE BILL CLAUSE 15 – “TAXING” CARERS?

1. SUMMARY

1.1 The specific mechanism for crediting care accounts set out in clause 15 of the Care Bill has a serious flaw which has not to date been widely appreciated. It would mean that, in some quite common situations, the consequence of family members providing unpaid care rather than asking the state to provide care would be that the person would pay substantially more towards the cost of their care than if the family had chosen not to do so — a consequence which might understandably come to be perceived as a “tax on carers” (and which might lead some people to look first to the state for support rather than making the most of family and community resources).

1.2 This submission explains how this problem arises, and suggests an alternative mechanism which would achieve broadly the same distributional outcomes without the perverse incentives. We have raised the general issue in our response to the DH consultation on funding mechanisms, and in related discussions with civil servants, but unlike most issues covered by that consultation this is a problem which could only be corrected by changes to the Bill itself and could not be dealt with in regulations and guidance.

2. THE PROBLEM

2.1 The basic policy intention of the Care Bill is to cap the amount which any individual might have to pay for their care. However the mechanism set out in clause 15 of the Bill is not a cap on total payments by...
individuals, but a cap on total expenditure by the local authority, actual or (in the case of people making private arrangements) notional.

2.2 This mechanism was proposed by the Dilnot report, though it was explained only briefly in that report, and many readers missed its significance. Its policy justification was to ensure that people with relatively low incomes would benefit from the cap. If the cap had applied directly to the total charges paid by individuals, people whose financial circumstances meant that they were only assessed as being able to pay a modest contribution towards the cost of their care would continue to pay charges for many years, and would often get no benefit at all from the cap. This was felt to be unfair, so it was proposed that what should be credited to the care account for people in this situation ought to be the total cost of their services, so that they would reach the cap after the same length of time as people who could afford to pay the full cost.

2.3 This mechanism was adopted in the Care Bill. Unfortunately it has serious unappreciated flaws. While it would spread the benefit of the cap more widely, it would have significantly unfair consequences for some people with carers.

2.4 The problem would arise in a particularly acute form where an older person with care and support needs owns their house but has only a modest weekly income. An example would be an older homeowner living on their own who is in receipt of Attendance Allowance and Pension Credit. If a person in this situation chooses to receive local authority services, they might typically be assessed as able to pay up to £50 per week in charges, but if they have limited support from carers it would not be unusual for them to receive home care and other services costing £200 per week. The care account of an older person in this situation would therefore be credited with £10,000 a year.

2.5 A second person in otherwise identical circumstances might have family members who decide to provide substantial support themselves, reducing the cost of the services which needed to be arranged by the local authority to £50 per week. The result would be that that person’s care account would be credited by only £2500 a year, though the charges paid by this person would be the same as for the first person (£50 per week).

2.6 If after three years both people’s condition deteriorates to a point where they need to move into a care home, the person whose family has provided most of their support will have £22,500 less in their care account than the person whose family have relied entirely on publicly-funded services, despite having paid the same amount in charges — and might therefore have to spend more of the value of their house on paying for their residential care. By providing care, the family would have reduced the costs to the public purse, but would in effect then be financially penalised for doing so.

2.7 There are potentially also further perverse consequences of the mechanism proposed in clause 15 — for instance if a local authority chooses (or is required by regulations) to provide some care and support services without charge, the cost to the public purse might be up to twice the cost of the services themselves, since the amount spent would also be credited to care accounts, potentially reducing the local authority’s future income.

3. A SUGGESTED SOLUTION

3.1 We think there is a straightforward solution, which would avoid the perverse consequences of the mechanism in the Bill, while still achieving the current policy objectives, including spreading the benefits of the cap widely.

3.2 The solution would work as follows:

(a) Clause 15 would be amended (with consequential changes in Clause 29 and possibly elsewhere), to provide that what would be credited to care accounts would be either the charges that the person had paid to a local authority or, for people paying privately with an “independent personal budget”, the value of that “budget” (which would also correspond to spending by the person themselves, and therefore be equivalent to charges).

(b) Clause 15(4) would be amended to provide that the cap on charges could vary depending on the financial circumstances of the person, as well as their age and description.

(c) Rather than setting a cap of £72,000 for all older people (and setting caps for younger adults based purely on their age when they first need care and support), regulations would provide that for people who ask the local authority to arrange care and support services, the cap would vary in a prescribed way depending on information gathered during the financial assessment required to set their charges. This would impose little or no additional administrative burden on local authorities, since they would already be required to collect the same information in order to set charges.

(d) Service users on lower incomes would be set a lower cap, designed to ensure that they could typically expect to reach the cap at about the same time as people who can afford to pay the full costs of their care.

(e) People making private arrangements would have their cap set purely on the basis of their age, unless they chose to request a financial assessment in order to benefit from a reduced cap (an option which would protect the small number of people with low incomes who might choose not to ask the local authority to commission their services).
3.3 The effect would be that, in the illustrative situation described above, both older people would have a cap set at a level substantially below £72,000, and both would have the same level of credits in their care account at the point when they needed residential care. Careful financial modelling would obviously be required to ensure that the overall costs to the public purse remained unchanged, but that would be an implementation issue rather than affecting the Bill itself.

January 2014

Written evidence submitted by the Chartered Society of Physiotherapy (CB 13)

INTRODUCTION

The Chartered Society of Physiotherapy (CSP) is the professional, education and trade union body for the physiotherapy profession. The CSP has 52,000 members, representing 95 per cent of qualified physiotherapists, as well as physiotherapy support workers and students.

Physiotherapy enables people to move and function as well as they can, maximising quality of life, physical and mental wellbeing. Physiotherapists work across sectors and care pathways, providing the ‘bridge’ between hospital, primary and community care, and across health and social care. Alongside other allied health professionals (AHPs), physiotherapists and support staff are central to the delivery of integrated care and keeping people out of hospital.

Physiotherapists and physiotherapy support staff work with a wide range of population groups, facilitating early intervention, supporting self-management of conditions and disabilities, promoting independence and helping prevent episodes of ill health and disability developing into chronic conditions, minimising or delaying substantial health and care needs.

Physiotherapy supports people in range of need areas, including musculoskeletal disorders; many long term conditions, such as stroke, multiple sclerosis and Parkinson’s Disease; cardiac and respiratory rehabilitation; children’s disabilities; women’s health; continence; mental health; and falls prevention among older people.

The CSP would be happy to provide any additional information or clarification on the issues raised in the evidence we present here.

SUMMARY OF CSP RECOMMENDATIONS

— Support the amendment to Clause 13 from Paul Burstow on eligibility criteria, making it clear that moderate care needs should be met.
— Strengthen the Care Bill to support fundamental reform of commissioning practices, to raise standards of care and employment.
— Supports the three amendments from Paul Burstow to clauses 88 and 89 that are intended to restore the powers of the Care Quality Commission (CQC) to review or investigate local authority social care provision or commissioning without first securing Ministerial approval.
— Signal a sea change in practice for social care commissioning, making it clear on the face of the Bill that forthcoming statutory guidance on commissioning will include time allocation to care, rates of pay, conditions and contracts of staff, and staff engagement, including through recognised trade unions.
— Clarify Clause 80 to ensure that duties on openness and transparency will apply equally to non NHS providers and to social care providers in the same way.
— Oppose the opposition amendment to apply the Duty to Candour to health and care professionals.
— Delete the ‘Lewisham Clause’ (Clause 118) and amend the Bill to ensure that the duties of commissioners to involve and consult patients includes recommendations of Trust Special Administrators.
— Amend Clause 99 to require Health Education England (HEE) to have regard for national need for services regardless of the sector they are delivered, meeting the demands of future service redesign and adopting a consistent approach to all groups of health professionals.
— Reinstate the clause previously included that allows the HEE to arrange national provision or direct one or more Local Education and Training Boards (LETBs) to do so on its behalf.
— Amend Clause 102 to add a requirement that how individual LETBS are organised and structured is transparent, and that it is clearly communicated publically how stakeholders and patients can engage with them.
— Amend Clause 102 and 104 to specify that Local Education and Training Boards (LETBs) must have regard to the need for and contribution of allied health professionals (AHPs) in all their strategic planning activities and that AHPs are involved in LETB decision making structures.
PART ONE — CARE AND SUPPORT

1. Setting the threshold for social care to support prevention and independence

1.1 The Care Bill sets out a welcome vision for social care, putting prevention, early intervention and wellbeing centre stage (Clause 2). However the framework for eligibility, coupled with chronic underfunding, seriously undermines the possibility of achieving this.

1.2 Local authorities have been limiting social care to people with substantial care needs only, with only a handful left who provide to people with moderate care needs. As a result the numbers of people receiving social care are falling, with many basic needs not being met. 97,000 fewer disabled people have been in receipt of social care since 2008, and among older people the figure is 250, 000 and 4 in 10 of working-age disabled people who receive social care say that it does not meet their basic needs, including eating, washing, dressing and getting out of the house. This should be recognised as a failure of our current system.

1.3 Guidance to the Bill suggests that the current eligibility criteria in the Care Bill assume a threshold of critical or substantial care needs, so effectively putting current practice on a statutory footing. The CSP believes that this is taking us in the wrong direction.

1.4 Not providing services for people with moderate needs is short-sighted. New research commissioned by the Care and Support Alliance found that one in three working aged disabled people say cuts in social care have prevented them from working or volunteering. Limiting access to health and care services in the community increases dependency on more intensive and expensive health and social care services further down the line.

1.5 Providing health and care support for people with moderate needs helps people to maintain independence and stay healthy, and saves money. For example, evidence shows that for every £1 invested in care for disabled people with moderate needs generates a saving of £1.30, and supporting people with moderate needs so that they can be independent, and in the case of working age people, work — £700 million saving to central Government through an increase in tax revenue and reduction in welfare spending.

1.6 The LSE suggestions an additional £2.8 billion would be required for councils to set eligibility at moderate care needs. This should be set in context of an overall budget spend for health and social care of £120 billion. The CSP urges Committee to accept the amendment from Paul Burstow to Clause 13 to define eligibility criteria.

PART TWO — CARE STANDARDS

2. Improving standards through better commissioning

2.2 The social care sector is too often characterised by poor standards, exemplified by 15 minute visits, with poor pay and conditions for those working in social care — with more than 307,000 people (20 per cent of the social care workforce) employed on zero hours contracts, typically for the minimum wage, and (as pointed out in the Cavendish Review) frequently less than the minimum wage when travel time in between visits is factored in.

2.3 While the Government has given public assurance that the Care Bill will eliminate 15 minute visits, where these are inappropriate, through the requirement for council’s to focus on an individual’s wellbeing, the CSP is not assured that this will be the case in reality unless it is built into the regulatory framework.

2.4 Evidence from Francis and related reviews demonstrated two points that need to be better reflected in the Care Bill. First is the role played by the focus on financially driven targets in undermining the quality of patient care. Second is the link between conditions of employment and care, with quality employment as a key underpinning for delivering high quality care, including good staff engagement, the health and wellbeing of staff, trade union representation, and safe staffing levels. Notably, the Keogh review discovered a relationship between mortality rates and levels of trade union organisation among staff.

2.5 The CSP asks the Committee supports the three amendments from Paul Burstow to clauses 88 and 89 that are intended to restore the powers of the Care Quality Commission (CQC) to review or investigate local authority social care provision or commissioning without first securing Ministerial approval.

2.6 However we believe that MPs need to go further than to instigate the sea change in commissioning that is required. As it stands it is largely reactive. The Government has agreed to statutory guidance on commissioning practices in relation to care. The CSP welcomes this commitment and asks Committee to make it clear on the face of the Bill that the guidance will include time allocation to care, rates of pay, conditions and contracts of staff, and staff engagement, including through recognised trade unions.

43 Changes in the Patterns of Social Care Provision in England: 2005/6 to 2012/13, Personal Social Services Research Unit, London School of Economics and University of Kent, December 2013
44 The Other Care Crisis, Scope, Mencap, National Autistic Society, Sense, Leonard Cheshire Disability, January 2013
45 Changes in the Patterns of Social Care Provision in England: 2005/6 to 2012/13, Personal Social Services Research Unit, London School of Economics and University of Kent, December 2013
46 Economic Impact of Social Care Services Assessment of the Outcomes for Disabled Adults with Moderate Care Needs. Final Report. Deloitte, May 2013
47 Written reply to the House of Commons by Care Minister Norman Lamb 20 June 2013
3. The Duty of Candour

3.1 The CSP welcomes the duty of Candour (clause 80) on provider organisations, and making it a criminal offence to give false or misleading information (clauses 90–92), and the overall approach to the Duty of Candour taken by the government.

3.2 To be effective this clause must apply to all providers. The CSP asks Committee to clarify Clause 80 to ensure that duties on openness and transparency will apply equally to non NHS providers and to social care providers in the same way.

3.3 We ask that Committee opposes the opposition amendment to apply the Duty to Candour to health and care professionals, rather than working with professional bodies to incorporate into professional standards. In our view this amendment works against the goal of making health and care organisations places where staff can be encouraged to learn and raise issues of concern.

4. New powers for the Trust Administrator — the Lewisham Clause (Clause 118)

4.1 Clause 118 allows that the Trust Special Administrator can decide to close a hospital that is financially viable in the interests of the ‘wider health economy.’ The CSP would urge the committee to delete this.

4.2 The Care Bill also says that duties of commissioners to involve and consult patients doesn’t include a duty to consult on recommendations of Trust Special Administrators. The CSP asks that the committee amend this to say that they must consult.

4.3 The background to both these elements in the Bill is the case of Lewisham hospital, which the Trust Special Administrator sought to close because of the financial difficulty in a neighbouring trust, and was overwhelmingly opposed by the local community, health commissioners and political leaders across the political spectrum in Lewisham. If the ‘Lewisham Clause’ had been in place then, Lewisham hospital would have closed in spite of this. In the CSP’s view this is undemocratic and runs contrary to the Government’s commitment to localism and participation in health and care, including in the new NHS five year strategy.

5. Health Education England and Local Education and Training Boards

5.1 The CSP welcomes the clauses in the Bill placing Health Education England (HEE) and Local Education and Training Boards (LETBs) on a statutory footing, and the role to provide sector-wide leadership and oversight of workforce planning, education and training.

5.2 We have some concern that there are different approaches to workforce planning being taken by HEE in relation to different groups of health workers, with some considered nationally and others on an area by area basis. This lack of consistency poses a particular risk to smaller health professions (including physiotherapy), where a series of local decisions taken without regard to the national picture can have significant unintended consequences for professions.

5.3 Furthermore, current workforce planning looks only at NHS services, and does not look at future needs across all sectors. Given the move to a more mixed health economy this approach urgently needs to be revised.

5.4 The other aspect of Workforce Planning that is critical is to move to planning based on how we want service to look in the future, considering the skill mix and approach necessary to deliver innovative and integrated services.

5.5 The CSP and others have raised these concerns with HEE. We welcome HEE’s recognition in its national workforce plan (December 2013) of the importance of adopting a consistent and strategic approach to workforce planning for all professional health groups, rather than perpetuating the current situation where national decision making predominates for some and local arrangements for others, including taking account of professions forming national mobile workforces and the impact of mobility throughout the UK and across national boundaries. It also recognises that forecasts of need must look at need for staff across all sectors, and that there is a gap in the evidence to do this which must be rectified.

5.6 The CSP asks Committee to amend Clause 99 to require HEE to take account of all these factors; the national need for all types of health service; needs across all sectors delivering services; meeting the demands of future service redesign.

5.7 Previously the Bill included a Clause ‘where HEE considers that it would be better for the provision of certain education and training to be made on a national basis, it may arrange for that provision accordingly or direct one or more LETBs to do so on its behalf’. This clause no longer appears to be in the Bill. The CSP asks Committee to reinstate this clause.

5.8 Because of the large degree of autonomy in how they are organised and structured, it is our understanding that the structure and make-up of LETBs varies considerably. Our sense is that this is having the unintentional

consequence of creating a lack of clarity and transparency about how LETBs are operating, gaining local information and representation and making decisions. The CSP asks Committee to amend Clause 102 by adding a requirement that how individual LETBs are organised and structured is transparent, and that it is clearly communicated publically how stakeholders and patients can engage with them.

5.10 Allied health professions are a cornerstone of effective reablement, rehabilitation and health prevention — for example the role played by physiotherapists, occupational health therapists and speech and language therapists in supporting people to be discharged as early as possible from hospital, prevent further health conditions, and regain independence. AHPs are also leaders in innovation, integration and service redesign, commonly working in multi-disciplinary teams and across sectors. It is essential that allied health professions have a voice in the new structures for workforce planning, education and research so that they can be informed by this experience. Some LETBs recognise this, and have elected to have an AHP representative on the core group and/or have established an AHP sub group to feed in. However other LETBs have not done so and physiotherapists and other allied health professions have little or no involvement in them to date. The CSP asks Committee to amend Clause 101 and 102 to require LETBs to consider the need for allied health professionals’ involvement in their strategic planning and decision making.

6. The future of social care

6.1 The Care Bill has not taken the opportunity to address the current crisis in care.

6.2 The social care system has been chronically underfunded for decades. This now compounded by 33 per cent cuts in local authority budgets by 2014. Over the past three years, £2.68 billion has been cut from adult social care budgets, 20 per cent of net spending. At the same time the number of working-age disabled people needing care is projected to rise by 9.2 per cent and the number of older people needing care will rise by 21 per cent between 2010 and 2020.

6.3 To prevent people from needlessly requiring hospital or residential care, helping people to get out of hospital sooner, and preventing readmission people need access to integrated health and care services in the community. This includes services that support rehabilitation, reablement and prevention, help people stay out of hospital and get people home from hospital without needless and costly delays.

6.4 While the requirement to carry out social care assessments of care needs is positive, without established services in communities to refer to they are not meaningful and there is a risk that they are just another administrative burden on local authorities.

6.5 Integration needs to be properly funded and is not fully achievable by moving existing NHS financial resources to social care, or visa versa. Access to integrated care services needs to be based on NHS principals — funded through taxation and free at the point of delivery, based on need and not the ability to pay.

January 2014

Written evidence submitted by Royal College of Nursing (CB 14)

1.1 With a membership of over 410,000 registered nurses, midwives, health visitors, nursing students and health care assistants, 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.

INTRODUCTION

1.2 The RCN has played a significant role in the debate around social care reform due to the key roles nursing staff play working within and across the health and social care systems. We know that nursing staff:

— 1.2.1 play a distinct and critical role in health and social care. They frequently work on the interface of the two care systems and work to ensure that patients do not notice where these start and end. Nursing staff carry out public health work, provide social care (although not officially termed as such), consider a range of safeguarding issues, such as their patient’s practical and emotional needs, and identify and refer patients to a range of different services, including those outside the care systems, such as benefits and welfare support.

— 1.2.2 manage patient referral, admission and discharge processes. Nurses are frequently responsible for resolving confusion over where a patient needs to be discharged to and ensuring there are appropriate resources to deal with the patient effectively when they are moved. This can often be complicated; it can be a time consuming, duplicative and a bureaucratic process, which ultimately takes nursing staff away from frontline care delivery.

— 1.2.3 deal directly with the impact of delayed discharge of patients from acute to social care or community, stemming in part from disputes over who pays and a lack of capacity in the NHS and
local authorities. This is a frustrating occurrence resulting in patients ultimately being cared for in inappropriate care settings.

— 1.2.4 too often discharge a healthy patient into the community only to see them readmitted into the acute setting days or weeks later due to inadequate community care and support, the so-called ‘revolving door’.

— 1.2.5 improve joint working between the health and social care teams through multidisciplinary team working and single assessment processes. District nurses, community matrons, clinical case managers and other community leaders are notable examples of where nurses take the lead in coordinating care and case management. Nurse specialists also promote all forms of continuity of care and are highly valued by people with long term and complex conditions.

— 1.2.6 are vital, clinical and care leads in care homes, providing health and social care to residents in one setting.

PART 1 CARE AND SUPPORT

Funding cap

1.3 The RCN welcomes the government’s intention to introduce a cap on care provision costs to alleviate the financial pressures upon individuals. However, at £75,000 we are concerned about how many people this will positively affect. The RCN believes that too many may be left unaffected and still face agonising decisions over how to pay their care bills. The RCN calls upon the government to reflect on its decision around the figure set as the cap and to revise it to one closer to that advocated by the Dilnot Commission of between £25,000 and £50,000.

1.4 When asked in 2011 what type of funding system they would support in the reform of social care, RCN members overwhelmingly supported a comprehensive system based on the same principle as the NHS. They were particularly concerned that a new system should be fair, and that people should not have to sell their houses to pay for their care.

1.5 In its response to the consultation ‘Caring for our future, implementing funding reform’ the RCN highlighted its concerns that any funding system that is too complicated or segmented will only exacerbate the current problems faced by the social care and health care systems. For example, duplicative eligibility form-filling and needs assessments, delayed transfers of care, result in many receiving inappropriate care or care in the wrong setting and health care nurses being taken away from frontline care.

Clause 3, Promoting integration of care and support with health services etc.

1.6 e strongly welcome this clause, having repeatedly highlighted the challenges of providing integrated care throughout a patient’s journey across the health and social care systems. However, the RCN believes that whilst the intent of the legislation is laudable there is a need for greater incentives to encourage integrated working and overcome the challenges that have previously prevented joint working. The RCN believes that such incentives will need to be legislated for to ensure the adoption of integrated working nationally.

1.7 While we recognise that localised services best serve local need, integrated care should be provided to a nationally consistent and standardised way of working. This will help people, staff and those in receipt of care, who move from one location to another, to have a clear understanding of how the local system operates and what it delivers.

1.8 The RCN supports the delivery of integrated health and social care, however with separate funding systems the RCN is mindful of the potential for a blurring or shifting of service responsibility between social and health care services. The RCN strongly supports the principle that nursing care, including when delivered in a social care context, should be universal, provided free at the point of delivery, based on clinical need and not ability to pay, and preferably financed through taxation. Funding being taken from the NHS budget needs to be ring-fenced to guarantee that it is actually being spent on social care provision to ensure the NHS isn’t still faced with filling the gaps in social care.

1.9 The RCN believe that agreeing on an unambiguous definition of integrated care will be vital to ensure patients, staff, carers, governing authorities and external agencies have a common understanding of both the term and its desired outcomes, so that they can work towards a common aim.

Clause 4, Providing information and advice

2.0 As the RCN has repeatedly noted, the current care system is complex and confusing, this is compounded by the lack of information about how the system works. Providing information and advice is crucial in helping people understand the system, know what to expect, and make appropriate choices for their needs. People often need to access care services when they are elderly, frail and vulnerable and with complex and multiple needs. They must, therefore, have access to information and support in a format appropriate to their needs. They will be making decisions that will impact on their health and wellbeing and so need to understand, for instance, why choosing care provided by registered staff and not non-registered staff might be more appropriate. They should be fully made aware of the benefits of some types of care services, and the risks of others.

Clause 5, Promoting diversity and quality in provision of service

2.1 The RCN welcomes this clause, particularly with reference to placing a duty on local authorities to promote quality in the provision of services. However, the RCN does not think it sufficient that the duty merely is the ‘promotion’ of quality. Local authorities are responsible for commissioning services from providers and have a duty to ensuring that these providers and services effectively meet the needs of individuals. The RCN does not believe that local authorities are fulfilling these duties and responsibilities if they commission providers that fail to deliver high quality care, and worse, that provide care that detrimentally impacts on the health and wellbeing of the individuals concerned.

2.2 As commissioners, local authorities must be part of a system-wide approach to safeguarding, and they must be in part held to account. They are also failing negligent of their role if they commission providers and services that are not sustainable in light of the vulnerability of the individual’s for whom services are provided. The potential impact of this was demonstrated through with Southern Cross, where the health and wellbeing and indeed lives of care home residents were put at risk following its business model’s failure.

2.3 During the bill’s passage, the RCN has supported Leonard Cheshire Disability’s ‘Make Care Fair’ campaign to end 15 minute home care visits. The RCN believes that those with a disability should not have to choose between one essential care function or another because visits are scheduled for so little time. Anyone who needs support getting up, washing, dressing, and eating should receive these basic rights with adequate time and dignity. The RCN would support amendments to guarantee the quality of service provision in this setting.

Clause 25, Care and support plan, support plan

2.4 The RCN fully supports people having control over their care and of person-centred or personalised care. With this in mind, the RCN has always maintained that personal budgets and personal health budgets must remain optional, as they may not be the preferred or most appropriate solution for some people, particularly those most vulnerable. However, we have concerns that personalised care and personal budgets are wrongly conflated, personal budgets are just one way to deliver personalised care.

PART 2 CARE STANDARDS

2.5 The RCN acknowledges and welcomes the government’s efforts to legislate recommendations of the Francis Report in to Mid Staffordshire NHS Foundation Trust.

2.6 The RCN supports moves that allow for better, clearer information on the quality of provider to be available for patients and stakeholders. We believe the government’s proposals charging the CQC with responsibility to develop performance ratings and introducing a failure regime on the grounds of quality of care are important steps towards addressing the imbalance that financial issues have more weight than quality, experience and care. Whilst we welcome the introduction of a Chief Inspector for Hospitals and Chief Inspector for Social Care, we would like to see more details of the practicalities of their responsibilities, for instance, how they will work with existing National Professional Advisors at CQC and other agencies such as Monitor.

2.7 The RCN believes that monitoring and inspections should bring in as much patient and staff insight as possible. This includes making use of the family and friends test, annual staff surveys, and patient and family complaints.

2.8 The RCN know that ratings work better in some settings than in others. Specific services are often simpler to inspect and rate, such as individual care homes, whereas, multi-service providers such as hospitals present greater complexities.

Clause 118, Trust Special Administrator

2.9 Undoubtedly the Trust Special Administrator (TSA) does have a place in the process of rectifying failing trusts and there will be occasions when it is important that speedy decisions are taken to address organisational failure. However, the RCN believes this should only be rarely enacted, as an option of last resort, in cases of
significant debt or deficit, and not for relatively small or moderate financial challenges. The TSA’s ability to make decisions quickly restricts the time available for consultation with the public and clinicians. A significantly time-constrained consultation process is not optimal, and should only be used in exceptional circumstances. The TSA must not become the mechanism of choice to routinely reorganise structures.

3.0 The RCN believes that any organisational and service reconfiguration should be considered on a local health economy and population basis, with key organisations coming together to lead the process and any decisions on change. We would expect Clinical Commissioning Groups (CCGs) to be a significant part of this process. When looking at a provider from a commissioner’s point of view it is vital to also consider its sustainability in the long term in the context of the local health economy. The RCN would like to see reconfiguration decisions being clinically led so that voices of clinicians are pivotal when shaping major service change. If there are savings to be made, and changes are inevitable because of financial constraints, it is important that politicians and trusts have an honest conversation with the public and clinicians about these savings and how they will be made.

PART 3 HEALTH EDUCATION ENGLAND

3.1 The RCN welcomes the establishment of Health Education England (HEE) and its responsibility for national oversight of education and training. It is an important development which will help protect funding for education and training and ensure it is spent efficiently and effectively on a national scale. The establishment of HEE presents a real opportunity to adopt an independent and comprehensive approach to health workforce planning that is responsive to both national and local issues around supply and demand.

Care Certificate for HCSWs

3.2 The RCN supported a number of amendments to the bill during its passage through the House of Lords, which called for mandatory training of health care support workers (HCSWs). To ensure the very best in patient care and accountability, it is crucial that this group of individuals, who are often working with the most vulnerable in our society, are trained and regulated properly. The RCN has long called for mandatory registration and training of HCSWs and we believe the government should introduce mandatory registration and regulation for this group. Throughout the longstanding debate on introducing a register of HCSWs, the RCN has stated that one of the overriding reasons is to ensure basic standardised training.

3.3 Therefore, the RCN particularly welcomed the government’s commitment at report stage of the bill in the House of Lords and in its full response to the Francis report, that it will be introducing a care certificate for HCSWs. Standardised training and national standards for HCSWs, who often care for the most vulnerable in our society, is absolutely essential and a certificated training programme is a notable step towards regulating this workforce. The RCN believes that HCSWs should only be allowed access to patients once they have proved themselves competent after completion of robust training that includes, but is not limited to, mandatory topics such as health and safety; basic life support; and moving and handling. This training should also include skills and knowledge development, which will enable the individual to care for patients in a dignified and compassionate manner. The RCN is working with HEE and other stakeholders to devise the structure of the certificate and implement the Cavendish review further.

PART 4 HEALTH RESEARCH AUTHORITY

Clause 109 Co-ordinating and promoting regulatory practice etc

3.4 Part 4 of the bill establishes the Health Research Authority (HRA) as a non-departmental public body. Clause 109 refers to the organisations and people which the HRA should co-operate with in respect of its functions. The list includes, amongst others, the CQC, the Human Tissue Authority, the Human Fertilisation and Embryology Authority and the Chief Medical Officer. Whilst the Chief Medical Officer is included, the Chief Nursing Officer is not, an oversight which the RCN believes should be put right for a number of reasons outlined below. The RCN is seeking to amend this section of the bill.

3.5 The nursing profession has a fundamentally important contribution to make in health and social care research, recognised by the UK Clinical Research Collaboration (UKCRC) and National Institute for Health Research (NIHR).

3.6 The paucity of evidence of what works in care and caring practices could be a factor in identifying what constitutes good levels of care. In times of austerity when resources are limited it is more important than ever to ensure that care and caring practices are both compassionate and effective. Research is essential to develop the knowledge base to underpin nursing practice and ensure that the deployment and interventions of the largest health care workforce are both efficient and effective.

3.7 Nurses play a central and fundamental role in achieving the government’s ambition for wealth creation through clinical and biomedical research. The nursing research workforce is recognised within NIHR as pivotal to the wider health and social care clinical research agenda, which in turn is recognised as a major
contributor to the UK economy. Much of the bill talks of promoting integration, it is therefore important that
the representative boards are multi-professional.

January 2014

Written evidence submitted by the Alliance for Inclusive Education (CB 15)

Background information for care and support bill amendments

The Alliance for Inclusive Education (ALLFIE) is a national campaigning and information-sharing network
led by disabled people. ALLFIE campaigns for all disabled people to have the right to access and be supported
in mainstream education. When ALLFIE talks about disabled people (and learners) we include disabled children
and young people with Special Educational Needs labels. ALLFIE believes that education should support
the development of physical, vocational and academic abilities through mixed-ability tuition in mainstream
schools, so that all students and children have the opportunity to build relationships with one another. ALLFIE,
our members and our networks believe that a fully inclusive education system will benefit everyone.

Whilst ALLFIE welcomes the Care and Support Bill, we echo Inclusion London’s concern that disabled
people’s independence, their rights of control and choice, should be at the core of the proposed legislation.
Nevertheless, our focus will be on Part 3 — the establishment of Health Education England as a statutory body
with oversight of health care education and training.

Role of health-related education in championing disabled peoples’ rights to health care provision

Education has a fundamental role to play in influencing disabled peoples’ experience of healthcare provision.
Traditionally, healthcare education has taken a negative and medicalised approach to disability, supporting the
idea that disabled people have less to offer than their non-disabled peers.

When healthcare workers have a negative perception of disability, it colours their judgement when deciding
on appropriate treatment and services, since making those decisions involves judging what treatments and
services are ‘worthwhile’ and cost-effective.

“If she had been a normal young woman we would not hesitate to treat her.” 1

Withdrawing or withholding healthcare services has resulted in the needless deaths of disabled people, as a
result of prejudicial and discriminatory decisions made on this basis. 22% of people with learning disabilities
were under the age of 50 when they died compared with 9% of the general population. This is the reason that
such prejudice and discrimination must be challenged from within the heart of health-related education. Health
education underpinned by the social model of disability 2 would have a profound impact on how working health
professionals understand disability, and inevitably lead them to challenge the barriers that disabled people face
within health care services. Health education as it stands, fails to challenge the negative attitude of healthcare
professionals towards disabled people.

Benefits of having disabled people as healthcare professionals

An inclusive workforce benefits both the healthcare workforce and healthcare service users. Dr Stephen
Duckworth, a respected GP and consultant, states that education plays an influential role in shaping the
attitudes of healthcare workers. In his PhD research Dr Duckworth found that medical students’ attitudes
towards disabled people worsened during their medical education. 3 When disabled people are involved in
healthcare education, then there is greater opportunity for such attitudes to be challenged, and more effective
ways of working with disabled people can be established. 4 When disabled people are employed as healthcare
professionals and trainers, non-disabled professionals benefit alongside healthcare users.

“Disabled people add immense value to the student body. They help any group understand and
appreciate diversity. It made a huge difference to the medical school when the first student in a
wheelchair was admitted. ‘Disabled people can make a unique contribution to patient care and,
indeed, to medical research by providing direct experience and knowledge of particular health
conditions or impairments. Patients often identify closely with disabled medical professionals who
can offer insight and sensitivity about how a recent diagnosis and on-going impairment can affect
patients. Such experience is invaluable to the medical profession as a whole, and illustrates the
importance of attracting and retaining disabled students.” 5

54 Mencap (2007) “Death by Indifference”
55 Social model of disability Focus is on society to remove the attitudinal, organisational and environmental barriers that
disabled people face in accessing educational and training opportunities and accessing public services such as healthcare.
http://www.ukdpc.net/site/images/library/Social%20Model%20of%20Disability2.pdf
Education 1988, 22, 501–505
Disability: Involving Patients with Disabilities as Medical Educators” Disability Studies Quarterly Fall 2004, Volume 24, No. 4
http://dsq-sds.org/article/view/883/1038
58 General Medical Council (2010) “Gateways to the Professions Advising medical schools: encouraging disabled students”
There are still too many barriers facing disabled people who want to work in healthcare. While acknowledging the discrimination faced by disabled people both within the NHS and by healthcare service providers, our focus is on the provision of health education and training as outlined in Part 3 of the Care and Support Bill.

Disabled people remain significantly less likely to be in employment than non-disabled people. In 2012, 46.3 per cent of working-age disabled people are in employment, compared to 76.4 per cent of working-age non-disabled people. As the health profession includes a multitude of healthcare roles, overall statistics are not currently available. However, where role-specific statistics are available, there is clearly a chronic under-representation of disabled healthcare professionals. For example, only 5.5 per cent of medical students, that is around 2,100 people, declared a disability in 2007/8.

Barriers Faced by Disabled Students Wanting to Enter the Healthcare Professions

Considering a Healthcare profession

Since the healthcare profession uses a medical model of disability, viewing disability as disabled people's problem, this affects the way that they are perceived, both as healthcare users and as providers. Focus on illness, disease, cure and restoring health leads to a view of disabled people as incapable, passive recipients of services by healthcare providers. Inverting roles, such as when a non-disabled patient consults a disabled doctor, may present a challenge to the status quo. Disabled people have qualified as health professionals, despite stereotyping and numerous other barriers. However, disabled people remain chronically under-represented in the healthcare workforce. For this reason it is our hope that the new statutory body, Health Education England, will be under a duty to work with careers guidance and education institutions, as well as with professional bodies, to spread the word that disabled people are welcome to train and join the healthcare profession once qualified.

Disabled people face a raft of obstacles to overcome, should they want to pursue a career in healthcare. These are met at many points in the process of gaining qualifications, from admissions procedures including entry requirements, to syllabus assessment, support provision while studying and fitness to practice.

Admissions

In common with many professions, historically application and selection for courses has become more stringent in recent years. Stricter and more specific criteria for application have further reduced opportunities for disabled people. A disabled medical student points out:

“Selection to medical school used to be done by straightforward interview. Now they have introduced psychometric testing and this might make it more difficult for disabled students unless adjustments are made.”

Competition to train as a healthcare professional has grown over the last decade, alongside the rising application to place ratio. As a result, universities are not only requiring students to meet higher entry requirements, but also to have a portfolio of extra-curricular activities and work experience that demonstrates a high level of commitment to their chosen healthcare profession. Alongside higher qualifications and developing a portfolio, students are also expected to sit additional standardised tests, such as the UK Clinical Aptitude Test (UKCAT).

“When I applied for nursing degrees and diplomas I was asked to perform tasks such as drawing up fluid in a syringe and injecting it into an orange or putting a plaster on a doctor’s hand. I was rejected from many higher education nursing institutions on occupational health grounds, as I was assessed as not having the physical dexterity the job required. Despite being very dejected, I didn’t give up and qualified as a nurse from Birmingham University in 2001. I made sure as a student I performed as many clinical skills as possible so I could practise them while being supervised.”

There is no evidence that raising the bar at admissions stage results in better qualified healthcare professionals, equipped with the right knowledge, skills and behaviours to work effectively.

“Having a degree does not necessarily make you a better nurse. However, it may make you better informed and would certainly address the issue of understanding evidence based nursing, which is crucial to all nursing professionals. Furthermore, as a degree prepared profession it gives the profession more kudos and equality amongst other healthcare professions...”

The purpose of raising academic standards without evidence of improved service user outcomes is questionable in itself. The additional barrier this creates for disabled people, when applying to undertake healthcare training, is unacceptable. Since disabled people are likely to be disadvantaged in the process of gaining academic qualifications, as well as finding it harder to complete extra-curricular support activities or gain work experience, this is a tangible additional disadvantage, likely to prevent people with disability from being considered for places on healthcare courses.

60 General Medical Council (2010) figures on website
61 General Medical Council (2010) “Gateways to the Professions”
62 Tarnia Taverner “Having a degree does not necessarily make you a better nurse” 20 July, 2010 Nursing Times.Net
To give an example, in order to gain relevant extra-curricular or work experience many disabled students require adapted equipment or personal assistance. However, funding is not available to meet these needs (such as from Access to Work) for disabled people to undertake work experience in a professional healthcare setting.

**Tutors**

The British Medical Association’s (BMA’s) Equality and Diversity in Medical Schools report\(^ {63}\) and the Department for Health’s document “Sharing the challenge, sharing the benefits — equality and diversity in the medical workforce”\(^ {64}\) identified improving disabled students’ access to medical education as one of the key challenges to providing equality and diversity in the medical workforce. The Allied Health Professional Support Service\(^ {65}\) has also identified that healthcare tutors and clinical educators can create barriers to learning. They do this by making assumptions about the ability of disabled people, based on their impairment and health condition. For instance, assuming that disabled individuals with a physical impairment will be unable to carry out medical procedures or will be too unstable to practice. Apart from making judgements based on stereotypical assumptions about disabled people, tutors may not be inclined or informed enough to meet disabled students’ access requirements whilst at university or in workplace training.

“The biggest obstacle so far has been my GP tutor. A failure of communication between him and the medical school meant that when I turned up for my first placement, he was not expecting the chair and the main meeting room, where drug rep lunches were held, was upstairs without a lift to get to it. At the end of my second week there, he told me I had to contact the dean. A fortnight later, my meeting with the Dean informed me that the GP tutor had decided (despite my occupational health clearance) that I was unfit to continue on the course! I was so angry with him and was glad that I could clear things up with ‘the guy at the top.’ Since then, my GP tutor has still been a huge problem. One week, we were spending the morning at opticians — five different places were chosen and the group split up so two went to each. Four of these places were wheelchair accessible. The fifth was not and that was the one he sent me to, and he was well aware that it wasn’t as well. I’m just annoyed that I have to put up with this attitude once a week for the whole year.”

**Support arrangements for disabled students completing healthcare courses required for professional registration**

The funding of support and equipment provision, to enable disabled students to complete healthcare courses, may be complex and demanding, and may require accessing a variety of funding sources, as well as meeting assorted eligibility criteria. For instance, a disabled NVQ Health and Social Care apprentice may draw upon Access to Work funding for a work placement, so long as it is paid work, additional Learning Support funding (at the college’s discretion) and social care support, so long as the person meets the ‘critical’ FCAS criteria. In this way funding arrangements can prove prohibitively complex, and be a barrier to disabled people taking health education courses.

Whilst the Disabled Students Allowance is welcomed by disabled HE students, it is unfortunate that it does not cover all disability-related assistance, and the amount awarded may not cover all the expenses required to complete their courses. At post graduate level there is less funding available, often resulting in a shortfall. In such instances disabled students have no choice other than to rely upon charitable grants provided by charities such as the Snowdon Trust which is completely unacceptable. Asemah, from Leeds, is undertaking a Master of Pharmacy qualification at the University of Bradford.\(^ {66}\)

“I started Pharmacy in September 2009, first year went great and I loved every minute of it. Unfortunately, in second year I was really struggling to do assignments, directed study and use my laptop as my needs had changed since starting university, so I applied to the Snowdon Trust for some support in the hope that they could help.

I am truly grateful to the Snowdon Trust for granting me funding for an iPad and the Supernova software.

Words cannot describe how happy I was when I found out my application had been accepted as Pharmacy means the world to me and I would have found it so difficult without this support. The grant has made a huge difference to my studies.

My iPad is amazing. I am able to read my e-texts, as well as the British National Formulary and the Medicines Ethics and Practice allowing me to make prescriptions in class. I can view lectures as they are being presented making it easier to see and follow the tutors.”

Funding is scarce or unavailable for disabled students taking OFQUAL and other professional body accredited courses, completed outside higher education institutions. So, disabled students completing a NVQ level 2 or 3 have NO ENTITLEMENT to a personal allowance to fund the cost of the equipment and support

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\(^ {63}\) British Medical Association (2009) “Equality and diversity in UK medical schools”

\(^ {64}\) Department for Health (2004) Sharing the challenge, sharing the benefits — Equality and Diversity in the Medical Workforce : Workforce Directorate

\(^ {65}\) Website link until 01/04/2014 http://www.ahpss.co.uk/

\(^ {66}\) Snowdon Award Scheme http://www.snowdontrust.org/your-stories/asemah/
they may need. These funding constraints deny disabled students the right to access the support they need to complete courses required to gain professional healthcare status.

AMENDMENTS

(1) PURPOSE OF AMENDMENT

To have a role in promoting inclusive education practice in health related courses.

New clause: Promoting Inclusive Education Practice.

When HEE undertakes its functions, it will promote equality of access to health-related courses by:

(a) Working with admissions tutors to develop procedures that avoid disadvantaging disabled applicants from consideration for admission onto a health-related education courses.

(b) Providing resources and expertise to build the capacity of health education providers to deliver inclusive health-related courses.

(c) Providing bursaries and assistance for disabled learners who need additional learning support that is not available through Post-16 institutions or training providers, or to ensure there is no shortfall relating to funding for higher education students through the DSA.

(d) Working with education providers to make their health-related courses, including any work-related experience, and assessment methods accessible and inclusive for disabled learners.

(e) Working with professional bodies and awarding bodies to establish inclusive methods of assessing workers’ competences.

(f) Providing course syllabuses that are accessible, can be differentiated and promote anti-discriminatory practices.

Why is the Amendment needed?

In order to meet the purpose it was set up for, HEE should have a clear strategic role supporting both the development of inclusive health-related education, and the funding to make that a reality. Without this, disabled people will continue to be prevented from accessing courses. In particular, funding issues, such as the DSA ceiling, or the channelling of ALS funding into segregated courses, will continue to actively prevent integration.

What will the amendment do?

Place HEE under a duty to support the evolution of a diverse healthcare workforce by ensuring that health education provision is inclusive, and provides the disability-related financial assistance disabled people need in order to attend and complete such courses.

What will be the result of the amendment?

HEE will have a proactive role in supporting inclusive education practise throughout the health-related education provision.

(2) PURPOSE OF AMENDMENT

The HEE will be placed under a duty to develop and support a diverse workforce, representative of the general population. It is not acceptable to have a workforce that excludes a particular section of the population. Access to healthcare professions such as medicine is becoming increasingly restricted 67

Proposed Amendment

Clause 86(1) Page 72 line 33 at end insert “HEE must exercise its functions with a view to ensuring that there is a diverse workforce that includes sufficient numbers of disabled persons with the relevant knowledge and skills to work as healthcare workers within the health service in England. Clause 86(1) Page 72 line 33 at end insert “HEE must promote inclusive health-related education and training for health-care workers”

Why is the Amendment needed?

We want the HEE to champion a diverse health care work-force and to promote inclusive education practise, whilst exercising its functions, such as commissioning health-related education courses.

What will the amendment do?

Impose a duty upon the HEE to promote inclusive education practise with the aim of having a diverse healthcare workforce that represents the general population.

What will be the result of the amendment?

HEE will be under a duty to promote inclusive education and a diverse workforce.

(3) **PURPOSE OF AMENDMENT**

HEE’s objectives, priorities and outcomes must be to reduce anti-oppressive practice when health workers are working with disabled healthcare service users and disabled people in the workforce. Disabled people are far less likely to be given appropriate healthcare services due to the prevalence of negative attitudes amongst health care workers. Education is a vehicle for challenging unacceptable disablism within the health service.

Amendment requirement

Clause 87 line 24 at end insert:

“HEE’s Education Outcomes Framework will include development and implementation of anti-discriminatory practices within the health-related professions.”

Why is the Amendment needed?

Disabled people have recommended that health-related education that champions anti-discrimination practice is central in order for health care workers to have the attitudes and values necessary to ensure that disabled people have the same rights as their non-disabled peers to access health care services as the general population.

What will the amendment needed?

The amendment will redress the discrimination disabled people face in accessing health care services and health care education.

What will be the result of the amendment?

Place positive pressure on health education providers and professional bodies to include disability/equality issues in their course curriculum and improve access to admission on healthcare courses.

(4) **PURPOSE OF AMENDMENT**

HEE will be under a duty to have regard for advice given by disabled people when exercising its functions.

Why is the Amendment needed?

Health care services and education must reduce disadvantage to disabled people, who are more likely to use health services than any other group. For example, two thirds of NHS clients are aged 65 and over and are likely to be disabled; disabled people, especially those with learning difficulties are more likely to face discrimination than other health care users. In order to properly inform the development of health care education and services, it is vital that disabled people are fully represented in the consultation process. 68

What will the amendment do?

Clause 89 Page 75 at end insert “disabled people who will use health services”

What will be the result of the amendment?

HEE will be obliged to have regard for advice given by disabled people.

(5) **PURPOSE OF AMENDMENT**

HEE and LETB will be placed under a duty to only commission education courses that are inclusive of disabled learners.

Amendment required

Clause 94 Page 79 line 12 insert at end “When HEE or LETB are commissioning health education courses, they will be inclusive of disabled students”.

Why is the Amendment needed?

From our experience education and training providers commissioned to work with apprentices may not be inclusive of disabled learners when they are on apprenticeship placements. The training providers often do not have sufficient experience and skills to work with a diverse range of learners.

What will the amendment do?

Place HEE and LETB under a duty to commission education and training providers capable of training a diverse work-force, including disabled people who want to pursue a career in health care.

Why is the Amendment needed?

HEE and LETB will only commission health related education courses that are inclusive.

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68 Age UK “Later Life in the United Kingdom July 2013” statistics
Medical Council (GMC) provides a number of case studies illustrating support provided to disabled students throughout their medical training.69

January 2014

Written evidence submitted from the Royal College of Surgeons (CB 16)

1. Introduction
1.1 This evidence from the Royal College of Surgeons (RCS) sets out our views on parts 2 and 3 of the Care Bill.

1.2 The RCS is broadly supportive of the Bill in its current form, although we do have some outstanding concerns, particularly about how the new ‘single failure regime’ will work in practice. There are also a number of other areas of the Bill which we feel could be improved or clarified; these are set out below.

PART 2: CARE STANDARDS

2. Duty of candour (clause 80)
2.1 The Government has asked our President, Professor Norman Williams, and Sir David Dalton, Chief Executive of Salford Royal NHS Foundation Trust, to assess whether regulations created by this clause should extend a duty of candour to cover moderate harm, as well as death or serious injury. The review has the aim of improving the reporting of patient safety incidents. A call for evidence has been launched and we will carefully examine the views of MPs and others on this important issue.

3. The ‘single failure regime’ (clauses 81-84)
3.1 The RCS has expressed concern about the proposed ‘single failure regime’, which is designed to tackle problems in finance, governance and the quality of care in NHS trusts.

3.2 While we welcome an equal emphasis on addressing both quality and financial failures, we have some outstanding concerns about the proposed roles for the CQC, Monitor and the NHS Trust Development Authority (NHSTDA) in this regime.

3.3 The RCS believes that this new regime is particularly complex — whereas the CQC will delegate its enforcement powers (in respect of bodies that do not meet essential levels of safety and quality) for NHS trusts and foundation trusts to the NHSTDA and Monitor respectively, it will retain its enforcement powers for social care, general practice and independent sector providers.

3.4 Robert Francis QC’s report made clear that overly complex regulation can contribute to failings in patient care.

3.5 While we are pleased to note the Government’s assertion that this Bill “ensures a consistent regime for trusts and foundation trusts alike”, we are nevertheless concerned about how the new regime will work in practice. In particular, we seek reassurance that the CQC, Monitor and the NHSTDA will work together to ensure that problems are acted upon in a manner which is both efficient and timely.

3.6 The following issues are of particular concern:

— Will Monitor and the NHSTDA be able to question the CQC’s findings and recommendations? What will happen if they disagree about whether action is needed?
— Will this additional level of complexity slow down action required to address failures?
— What will the Government and regulators do to ensure patients understand who is responsible for enforcement action in the NHS, the independent sector, and social care?

4. Statutory independence of the CQC (clause 88)

4.1 The RCS welcomes the proposal to give the Care Quality Commission (CQC) statutory independence when reviewing NHS providers, as set out in clause 88. This should help to increase public confidence in the regulator.

4.2 It will be important for statutory independence to be matched by day-to-day autonomy from ministers who remain ultimately responsible for the regulator.

4.3 The CQC has undergone significant upheaval in recent years, and is in the process of implementing fundamental changes to the way it carries out its work. We hope greater independence will bring more stability to its regulatory model.

4.4 We are pleased by its efforts to engage with the royal colleges in reviewing its inspection model, and we look forward to supporting the regulator to better involve clinicians in its inspection teams.

69 General Medical Council (2010) “Gateways to the Professions Advising Medical Schools : Encouraging Disabled Students”
5. Extending the powers of Trust Special Administrators (clause 118)

5.1 This clause, introduced in the Lords, gives the power to Trust Special Administrators to make decisions that go wider than a trust under special administration, including other NHS trusts and foundation trusts.

5.2 We believe this is a logical change as in many instances of trust failure the solutions are unlikely to be found simply within the existing organisation. However, we believe, along with the Academy of Medical Royal Colleges, this clause should be amended to require the Trust Special Administrator to consult with neighbouring trusts if its recommendation would have an effect on their services. Any proposals should then be put forward to the affected local populations.

6. Regulation of healthcare support workers

6.1 We welcome the recommendation from the Cavendish review that all healthcare assistants and support workers should undergo the same basic training and achieve a certificate of fundamental care before they can care for people unsupervised. We strongly encourage the Government to enact this proposal.

6.2 We also believe the Government should go further than this, and introduce regulation that would ensure that any such workers who are found not to be fit and proper persons are barred from holding similar positions in future. We support amendments to the Bill that would help to achieve these aims.

PART 3: EDUCATION, TRAINING AND RESEARCH

7. Health Education England, and LETBs (clauses 94 and 101)

7.1 The RCS supports the proposal in the Care Bill to place Health Education England (HEE) and Local Education and Training Boards (LETBs) on a statutory footing. We have been encouraged by the work of HEE to date. Medical Education England (which it replaced) acted in an advisory capacity but HEE is likely to have greater influence as it controls the education and training budget and acts as the body responsible for improving the quality of education and training.

7.2 During scrutiny of the Draft Care and Support Bill we raised concerns that clinicians were excluded from the new education and training structures. We are pleased to see that the Care Bill now requires clinicians to be represented on both HEE and LETBs. During the House of Lords Committee Stage we were also pleased that Earl Howe acknowledged that HEE and LETBs would need to tap into the “knowledge and expertise” of bodies such as the medical royal colleges in order to effectively carry out their roles.

8. Requirements on the independent sector (clause 103)

8.1 The independent sector is playing an increasing role in the NHS — particularly in elective surgery. Although the independent sector only provides roughly 3% of all elective NHS care, for elective hip and knee surgery this figure rises to almost a fifth (19%).

8.2 We therefore welcome the strengthened requirements on all providers of NHS services to co-operate with LETBs, including through the supply of data about their workforce.

9. Involving clinicians in local education and training plans (clauses 104(4))

9.1 The RCS is pleased that the Care Bill requires clinicians to be represented on both HEE and LETBs. However, we feel it would be helpful if clause 104(4) made it clear that LETBs will need to involve local healthcare professionals when developing their education and training plans.

10. Accountability of the Centre for Workforce Intelligence

10.1 Clarification is needed about how the Centre for Workforce Intelligence (CfWI) will work with HEE.

10.2 The CfWI was set up in 2010 to advise the Government on long-range forecasts of workforce needs in the health and social care service. The CfWI is currently accountable to the Department of Health but the Bill is silent about its relationship with HEE despite the important role it plays in data analysis of the workforce. We would welcome public clarification from the Minister about its intended relationship with HEE.

11. The Health Research Authority (clause 107)

11.1 The College welcomes the establishment of the Health Research Authority (HRA) and supports the move to place it on a statutory footing. We believe it will help to streamline research bureaucracy and we support its purpose of protecting and promoting the interests of participants, potential participants and the general public in health and social care research.

11.2 Reducing research bureaucracy is important for helping to foster a culture that encourages medical professionals to take part in research, and we would welcome clarification from the Minister about how the Government is working to achieve this.

70 http://www.nhsconfed.org/Networks/NHSPartners/Pages/Data.aspx
11.3 The College’s views on how to improve medical innovation in the NHS can be found online here.

January 2014

Written evidence submitted by Elizabeth Ayres (CB 17)

With reference to the above, please note the following:

1. People who own their own property which is only worth approximately £72,000 will lose the entire value of their property, whilst those residing in properties worth millions will keep their phenomenal wealth intact. Consequently, this bill targets the poor living in the lowest value of property the hardest, i.e. one bedroom or park homes etc.

2. Couples whose property may only be worth the equivalent of 2 x the £72,000 cap will lose their home in their lifetime, whilst the wealthy keep theirs.

3. What about where one partner whose pension is too poor to exist on and relies on their partner’s income to live in their current home, who has been taken into care, and cannot continue to live in their home without this income, and therefore has to sell up and move. For example, if the property is only worth £180,000–£200,000, and the less well off partner has to sell up and hand over £72,000 out of the value; What exactly is the now homeless partner supposed to buy somewhere else to live, with the remainder of the value. £100,000 – £120,000 will not buy even a one bedroom property in today’s market. So you have hit the poor at the bottom of the heap again, whilst the wealthy carry on as before.

4. What about couples who have a disabled child/adult residing with them because they have not been able to leave the family home which is of a low value. Are you going to rehouse them when you evict them and confiscate the property or leave them homeless?

This is a bill to protect those with wealth, whilst the poor continue to be targeted. My husband and I have worked and saved all our lives, but because our home is considered to be of a low value in relation to this ‘cap’, we will lose it in our lifetime and our daughter who has a disability and consequently still living with us and for whom we have not claimed one penny for looking after her, will be left without a roof over her head.

January 2014

Written evidence submitted by Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) (CB 18)

1. **THE LOCAL GOVERNMENT ASSOCIATION (LGA)**

1.1 The LGA is the national voice of local government. We work with councils to support, promote and improve local government.

1.2 We are a politically-led, cross party organisation which works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

2. **THE ASSOCIATION OF DIRECTORS OF ADULT SOCIAL SERVICES (ADASS)**

2.1 ADASS represents Directors of Adult Social Services in councils in England. As well as having statutory responsibilities for the commissioning and provision of adult social care, ADASS members often also share a number of other responsibilities for the commissioning and provision of housing, leisure, library, culture, arts, community services and a significant proportion also hold the statutory role of children’s services Director.

3. **SUMMARY**

3.1 For a number of years local government has been at the forefront of making the case for change in the way that support and care is commissioned and delivered. We broadly support the proposals set out in the Bill.

3.2 The reforms being implemented through the Care Bill need to be fully costed and funded as new burdens. This means funding both implementation in 2015/16 (for which £335 million has been allocated) and supporting on-going running costs (money for which will be allocated through future Spending Reviews).

3.3 Assurance that there is sufficient funding for the reforms is essential and there should be a mechanism for providing this. Assurance could, for example, be built into the process by requiring the Care and Support Reform Programme Board to confirm that it is confident in funding levels as a pre-condition of implementation. The LGA and ADASS are calling for the Department of Health to make sure that there is sufficient funding, for example, to cover the additional duties relating to carers, social work in prisons, the potential impact of introducing the principle of general wellbeing to the eligibility criteria and to cover the impacts of the bill upon ordinary residency costs.
3.4 The LGA and ADASS recommend that a national body oversee and administer the universal Deferred Payment Agreements (DPAs). Through their own work, including workshops with councils, the Chartered Institute of Public Finance and Accountancy (CIPFA) have similarly concluded that deferred payment should be overseen by a national deferred payment company. Whilst the Government has already committed £110 million to funding new burdens of DPAs, a nationally-run scheme will remove any financial and reputational risks to councils if this funding is inadequate. This would provide councils with the flexibility to opt into a national framework for deferred payments should they wish to do so. The system would be similar to the way the national Student Loans Company operates.

3.5 There is much detail still to be provided by regulations. We understand that there will be 25–30 pieces of secondary legislation required alongside statutory guidance in areas such as eligibility, assessments, charging, the operation of the care account, annual reporting and universal deferred payment. Until this detail is available, it is difficult for local authorities to start working through how they will implement the Bill.

4. FUNDING

Baseline funding

4.1 A fundamental difficulty with the Care Bill’s proposals is that they detach policy direction and decisions from financial direction and decisions. The overall context in which the Bill is being considered, namely the need to identify further savings across the public sector, does not fit well with the aspirations of the Bill.

4.2 Financial sustainability is the greatest challenge facing local public services. In the period of the current Parliament, local government’s core funding will fall by 40 per cent and the Audit Commission’s Tough Times 2013 report independently verifies the huge financial challenge faced across local government.

4.3 The funding gap is growing at around £2.1 billion a year. It is created by a combination of funding reductions and spending pressure. If current Government proposals are confirmed, this could be as high as £15.3 billion.

4.4 In addition, the recently published provisional local government finance settlement confirmed that the central government grant to run local services will fall by 8.5 per cent over the next two years, which includes NHS support for social care. Discounting the NHS support for social care, which is not available for shire district councils, the reduction is 15.9 per cent.

4.5 Despite councils’ best efforts to protect frontline services, the reality of cuts on this scale has meant that adult social care has not been immune to their impact. Adult social care budgets have therefore reduced by £2.68 billion over the last three years (20 per cent of the budget), compounded by the cost of demography which is approximately 3 per cent. It costs around £400 million a year just to meet on-going demographic pressures.

Funding for the Care Bill reforms

4.6 The June 2013 Spending Round announced £335 million for implementation in 2015/16, which we understand breaks down as follows:

— £145 million for early assessments and reviews.
— £110 million for deferred payment (cost of administering the loans and the loans themselves).
— £20 million for capacity building including recruitment and training of staff.
— £10 million for an information campaign.
— £50 million for capital investment, including IT systems (this sits within the Better Care Fund).

4.7 The Department of Health has also identified £135 million of other costs associated with reform to cover, for example, national eligibility, training for social workers, and the implementation of statutory Safeguarding Adults Boards. The Government’s position is that these costs should be funded through the Better Care Fund. Local government does not oppose this money sitting in the BCF. These costs should however cover new burdens meaning that the £135 million has to be new money to councils.

4.8 The success of the Bill will however be jeopardised if the reforms are laid over a system that is itself underfunded.

5. FURTHER ASSURANCE MECHANISM FOR FUNDING

5.1 We recommend that a new clause be inserted into the Bill to provide assurance that the funding for the reforms is adequate. The Care and Support Reform Programme Board brings together senior figures from central and local government as well as senior figures from the wider sector.

5.2 The Board would provide the assurance as a precondition of the provisions being implemented in 2015/16. This would provide a formal mechanism which would provide assurance that the costs of reform are sufficiently funded.
6. Deferred Payment System

6.1 We recommend introducing a new clause into the Bill to create a national system for running deferred payment agreements and loans. A national body would oversee the operation of the deferred payments so as to mitigate the financial and reputational risks that councils would be exposed to if they are to run it. Such a body overseeing a deferred payments system would help achieve economies of scale and strengthen public confidence in the process.

6.2 The Bill should provide councils with the flexibility to opt into a national framework for deferred payments should they wish to do so. CIPFA, through their work with local government, have arrived at a similar conclusion.

6.3 The LGA and ADASS have analysed the Department of Health impact assessment for the deferred payment system. The Department models the cost of the scheme based on assumed average length of a DPA. We have compared their estimates against the costings developed by a London borough that are based on assumed average length of stay in residential care. In our opinion a likely figure for the cost of deferred payment lies somewhere in between these two sets of figures.

6.4 Our assumptions are based on the mid-point between the Government’s figures and the London Borough’s initial estimate of costs (the Government’s estimates of cost are far lower than the London Borough). LGA calculations are as follows:

- Average scheme length of 2.7 years, with another 0.4 years on average to recover the debt.
- Average annual cost of care per person of £18,800 in year one, uprated by inflation + 2 per cent thereafter (the uplift is in line with the impact assessment).
- Average number of people joining per year of 6,500 in year one, uprated by demographic growth thereafter.
- Interest is assumed to cover the cost of borrowing and other similar elements, and as such both factors are excluded from the calculations.

6.5 Our analysis shows the costs of deferred payment as follows:

<table>
<thead>
<tr>
<th>Total value of loans / £ million</th>
<th>London borough</th>
<th>Government</th>
<th>LGA</th>
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<tbody>
<tr>
<td>2015/16</td>
<td>107</td>
<td>139</td>
<td>122</td>
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<tr>
<td>2016/17</td>
<td>331</td>
<td>147</td>
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<td>2017/18</td>
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<td>230</td>
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</table>

6.6 The crude year one cost is likely to be near, or somewhat in excess of, £110 million. It includes the cost of administering the loans, and the loans themselves. This will largely be dependent on the number of people opting into the system.

6.7 In the longer term, the deciding factor in many ways is the number of years it takes for an average deferred payment agreement to finish and the debt to be recovered. The longer this period, the more debt councils will have to manage at any one time. After this initial shock, there is some ‘levelling off’. The main factors affecting the cost to councils will be demographic pressure, inflation and the cost of borrowing.

6.8 Our figures are indicative only at this time and we will be doing further work to understand the likely cost of deferred payment. What is clear, however, is the key risk at play; whether central government has underestimated the average length of the DP agreement. If it has, local government could be exposed to significant reputational and financial risks. This risk is best managed at a national level through a standalone body whose financial risk is underwritten by central government.

January 2014

References

Written evidence submitted by the National Autistic Society’s (CB 19)

INTRODUCTION

1.1 The National Autistic Society (NAS) is the UK’s leading charity for people affected by autism. We have around 20,000 members and 100 branches, who are at the heart of what we do. We provide a wide range of advice, information, support and specialist services to 100,000 people each year. A local charity with a national presence, we campaign for lasting positive change for people affected by autism, and empower local people to influence change they will experience at a local level.

1.2 Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. It is a spectrum condition, which means that, while all people with autism share certain difficulties, their condition will affect them in different ways. Some people with autism are able to live relatively independent lives but others may need a lifetime of specialist support. People with autism may also experience over- or under-sensitivity to sounds, touch, tastes, smells, lights or colours. More than 1 in 100 people in the UK has autism.\(^71\)

1.3 Too many adults with autism are still waiting for the everyday support they need. In a recent survey by the NAS, 70% of adults with autism and their carers who responded said they are not receiving the help they need from social services.\(^72\)

1.4 Local authorities frequently do not identify adults with autism living in their area and do not plan and commission services that meet their needs.

1.5 Local authorities tend to provide services via specific teams which are categorised into client groups. Consequently, people with autism will usually come into contact with the learning disability team and/or the mental health team. However, as autism is a developmental disability and not a learning disability or a mental health problem, many people with autism, and particularly those with Asperger Syndrome or high-functioning autism find themselves “falling through the gap” between learning disability teams and mental health services, as both refuse to take responsibility for them. Too often, people with autism find they don’t “fit” into existing structures and fail to access the help they need as a result.

1.6 Where one of these teams has ‘taken responsibility’ for an individual with autism, the team’s lack of understanding of the condition often means that the support available is not tailored to their specific needs.

1.7 The Autism Act 2009, which became law as a result of cross party consensus, was developed to address some of these challenges. It is starting to make some difference, but our research through our Push for Action campaign shows that there is still a long way to go to ensure that adults with autism can get the help they need.

1.8 The Care Bill is central to making sure that the Autism Act delivers for adults with autism. The NAS has particular concerns about four areas of the Bill in relation to the Act and more widely in ensuring that adults with autism can access the support they need:

- Ensuring that duties included in the statutory guidance that was issued as a result of the Autism Act will continue to apply to local authorities and NHS bodies.
- Improving access to trained community care assessors.
- Securing sufficient sustainable funding for social care and setting the right level of eligibility.
- Ensuring accountability around preventative services.

1.9 The National Autistic Society is a key member of the Care and Support Alliance and support their briefings and amendments on the Bill.

THE AUTISM ACT

2.1 The Autism Act 2009 is England’s only disability-specific legislation. The Act led to the publication of the adult autism strategy for England and crucially statutory guidance which sets out duties on local authorities and the NHS to improve the lives of adults with autism across England. As a result of the Care Bill, all current regulations and statutory guidance relating to social care will be re-issued and brought together in one place. For the most part these regulations and guidance will only apply to local authorities. However, the Autism Act statutory guidance applies to both local authorities and the NHS.


2.2 The NAS is keen to ensure that the way that the new regulations and guidance are issued following the passing of the Care Bill ensures that the Autism Act statutory guidance continues to apply to the NHS as well as to local authorities to ensure the ongoing implementation of the Act.

2.3 For instance, the statutory guidance gives Clinical Commissioning Groups responsibility for developing a diagnostic and care pathway for adults with autism. Diagnosis is the crucial first step for someone with autism towards understanding their condition and getting the support they need. However, the NAS’s research, as part of their Push for Action campaign, found that there is a pathway in place in only 63 out of 152 local authorities73, showing the need for a continuing duty.

2.4 The statutory guidance also states that NHS bodies and NHS Foundation Trusts should ensure autism awareness training is available to all staff working in health care. As a minimum, autism awareness training should be included within general equality and diversity training programmes. The guidance also states that more specialist autism training for certain staff is expected and for GPs in particular. The reference to GPs was included following a survey by the National Audit Office in 2009 which found that 80% of GPs felt they needed more understanding and awareness of autism and where to refer people with autism on to for help and support74.

2.5 We would like assurance that the statutory guidance issued under the Autism Act will continue to apply to the NHS, when it is re-issued this year.

ASSESSMENT

3.1 We welcome the Government’s recent amendment to the Care Bill to enable the development of regulations that specify where community care assessments should be carried out by assessors with specific expertise. These regulations should look at the specific needs of adults with autism, in line with the Autism Act statutory guidance.

3.2 Community care assessors can easily misunderstand the needs of someone on the spectrum if they do not have experience and knowledge of how to communicate with someone with autism or of the impact of the condition on someone’s day to day life. People with autism have three main areas of difficulty: social interaction, social communication and social imagination. Assessors often fail to adapt assessments to reduce the impact of these difficulties.

3.3 Social interaction difficulties can make it hard for a person with autism to explain what support they want, or need. The person may not wish to engage with or understand how to take part in an assessment. Non-specialist assessors can mistake this for failure to consent to an assessment.

3.4 Social communication difficulties include a lack of spoken language for some, problems understanding the ‘gist’ of what people are saying, and thinking people always mean exactly what they say. People with autism can therefore misunderstand or misinterpret what has been said to them. They may find it difficult to express, or accurately represent, their own needs during assessment. A person may also struggle to understand questions and intentions, unless they are made absolutely clear and unambiguous. For example, if a person with autism is asked, “are you able to wash yourself on your own”, they may reply “yes”, but omit to mention that this is with verbal prompting at every stage.

3.5 Social imagination difficulties include problems with predicting what will or could happen next. It is hard for people with autism to understand their own needs or imagine what alternatives there may be to their current situation. They may not have the insight to realise what information is required during an assessment. People can also become uncomfortable talking about support that involves changes to an established routine or a move to a different service.

3.6 People with autism are often assessed by non-specialists or are offered a “specialist assessment”, but with a learning disability team. Assessors, particularly those used to assessing those with a learning disability may mistake an adult with high-functioning autism, who may be well educated and articulate, as therefore able to look after themselves with minimum input and support, when this may not be the case. Alternatively, someone with both autism and a learning disability may not have their autism taken into account and is therefore provided with inappropriate and maybe even damaging, services as the following quote from a parent demonstrates:

“My son has been placed twice now in accommodation unsuitable for his needs with disastrous results. We are now picking up the pieces and we have him at home. We have been told by social services that they have nothing for him.”

3.7 For an assessor to comprehensively and fairly assess someone with autism, they will need to have knowledge and expertise in adapted communication, devising different ways for people to express themselves and having the patience and understanding to support people with challenging behaviour. They will also need to have a clear understanding of the types of difficulty that someone with autism is likely to experience and the impact that this has on day to day life.

73 Ibid
74 National Audit Office (2009), Supporting people with autism through adulthood. London: The Stationery Office
3.8 In the statutory guidance that was published as a result of the Autism Act, the Department of Health provided clear direction that autism training is essential for community care assessors, to ensure the needs of adults with the disability are fairly assessed. It states that ‘local areas should develop or provide specialist training for those in key roles that have a direct impact on access to services for adults with autism — such as GPs or community care assessors’, so that ‘within each area, there are some staff who have clear expertise in autism’79. However, National Autistic Society research found that only just over half of English local authorities had specialist training available for their staff. Crucially, only one in three adults with autism told the NAS that, in their experience, social workers have a good understanding of autism6.

3.9 We would like assurance that the regulations on assessment will specify autism as a key group of people who will need specialist assessments, in line with the Autism Act statutory guidance. We are keen to work closely with the Department of Health on the development of these regulations.

3.10 Regulations on assessment will also need to be clear that social and communication needs are given equal weight to physical needs, to ensure the clear identification of the specific needs of adults on the spectrum.

ELIGIBILITY AND FUNDING

4.1 As a result of insufficient funding, a significant number of adults with autism are not eligible for support under the current system, leaving their needs unmet. A sustainable solution for future funding is therefore vital to ensuring that adults with autism can access the support they need to play active parts of the community and prevent them from needing crisis care.

4.2 Along with our colleagues in the Care and Support Alliance, we believe that the new eligibility threshold should be equivalent to “moderate needs” under the current system. This is essential if the Government is to succeed in its stated aim to prevent or delay care needs from developing, rather than only intervening at crisis point. This will actually save Government money in the long run.

4.3 The NAS, along with Scope, Mencap, Leonard Cheshire Disability and Sense have produced a joint report supported by economic modelling by Deloitte which shows the cost savings that can be made by investing in support for people with ‘moderate’ needs.

4.4 The ‘Ending the Other Care Crisis’77 report, has shown that due to preventing escalating needs, for every £1 invested in supporting a working aged disabled adult with moderate level needs this generates returns of £1.30 for people, carers, central and local Government.

4.5 We urge the Minister to consider the economic modelling produced by Deloitte, which demonstrates the savings that can be made by setting eligibility at the equivalent of moderate.

PREVENTATIVE SERVICES

5.1 The National Autistic Society welcomes the emphasis on the principle of prevention in the Bill but believes that in order for it to have a real impact on the provision of services, it must be further entrenched and ensure there is clear accountability for local authorities to deliver their duty of prevention.

5.2 Social care must no longer be a service of last resort. Under the current system, too many people only become eligible for support when their needs become acute and they require intensive, high level care and crisis management.

5.3 Many adults with autism would benefit greatly from low level services such as befriending or social skills training. These would help them to avoid isolation and participate in society. Lack of access to these services can have a devastating impact. A third of adults with autism responding to an NAS survey said they had developed severe mental health problems as a result of lack of support.78

5.4 Moreover, evidence from the National Audit Office (NAO) shows that providing low-level services is cost effective and prevents people from developing more complex problems.79 The report stated “Beside the negative impact of such crises on a person’s life, acute services are also expensive, with inpatient mental health care costing between £200 and £300 per day”80

5.5 The NICE guideline on autism in adults highlighted that investing in supported employment for adults with autism is cost-effective.81 According to NICE: “positive effects for supported employment programmes appear to stretch beyond the direct impacts on employment, with additional improvements observed for autistic behaviours, quality of life, and executive function.”82

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78 Department of Health (2010), Implementing Fulfilling and Rewarding Lives. p11
76 Ibid
80 Ibid
5.6 Enshrining prevention in the Bill is also important where older people with autism are concerned. Many middle aged or older people reach a "crisis point" when their parents or carers pass away. Appropriate identification, awareness and assessment of needs before this point is reached are vital.

5.7 Recent research by the NAS showed that 66% of respondents over 55 have not had their needs assessed since they were 18. Significantly fewer older respondents had their needs assessed in the past two years, compared to younger respondents.83

5.8 Given the importance of low level, preventative services, we would like to know how the new legislation will ensure that local authorities can be held to account for delivering their duties of prevention.

CONCLUSION

6.1 On the whole The National Autistic Society welcomes the framework that the Bill sets out for social care.

6.2 However, we have significant concerns that too few adults with autism will be able to benefit from the reforms, as currently drafted.

6.3 To make sure the reforms are fair for this group:
   — National eligibility should be set at the equivalent of moderate;
   — More attention needs to be paid to ensuring that preventative services are developed; and
   — The Government needs to ensure that the intentions of the Autism Act 2009 are integrated into the reforms.

January 2014

Written evidence submitted for Essex County Council (CB 20)

SUMMARY

Please find enclosed issues and concerns that Essex County Council (ECC) would like members of the Public Bill Committee to explore during your deliberations. In particular, Essex County Council would welcome:

(a) Clarity around certainty of funding for the cost of these reforms. ECC is concerned that the Government has significantly underestimated the cost and we support the inclusion of two LGA-sponsored amendments (see paragraphs 1.4–1.6).

(b) Removal of Section 1(2) from the Bill. While we support the inclusion of the wellbeing principle in Section 1(1), we do not believe that the list set out in Section 1(2) should form part of primary legislation. Section 1(2) also seems to pre-empt work underway by the Government to develop new national minimum eligibility criteria (which won’t be formally consulted on until May 2014).

(c) Clarity about whether local authorities will have the power under the Bill to delegate responsibilities under sections 9, 10 and 27 to a third party (namely in relation to the carrying out of assessments and reviewing of support plans).

(d) Provision for a new clause (proposed by the LGA) for the establishment of a national body to oversee and administer the proposed Deferred Payments Scheme.

(e) Clarity on whether the cap on care costs (Section 15) will be applied retrospectively to those already receiving care and support.

Our enclosed paper sets out more detail on these issues and others we would welcome the Bill Committee exploring.

Finally, Essex County Council is also concerned at the very short timescales for local authorities and the market to prepare for such fundamental reforms by April 2015, especially when the detailed regulations have still to be published. If the implementation is rushed, the reforms could be inadequately supported and potentially unstable when they are scheduled to ‘go live’ in April 2015. This is in nobody’s interests and we have called on the Government to consider delaying the implementation of the Bill until April 2016.

Essex County Council would welcome any opportunity to meet with the Bill Committee to discuss our concerns.

1. Adequate funding

1.1 Essex County Council (ECC) is concerned that the Government has significantly underestimated the cost of the reforms. Without adequate funding, the reform of care and support will be unsustainable, unstable and place significant additional financial burdens on already over-stretched council budgets when the reforms are scheduled to be implemented in April 2015.

1.2 ECC has set out in our consultation responses our concern that the draft national minimum eligibility criteria (although being classed as ‘substantial’) is actually a move towards ‘moderate’. ECC has carried out a review of a random sample of cases where people had been assessed as not having eligible needs under the existing threshold of ‘substantial’. Our review suggested that 23% of those people not currently deemed eligible for care may meet the eligibility threshold each year under the new regulations. This pressure is currently unfunded.

1.3 The Government has calculated that the cost of moving to the new national minimum eligibility criteria will be £23 million nationally — based on those operating at ‘critical’ moving to ‘substantial’. The real impact would be the cost of 130 local authorities currently operating at ‘substantial’ facing increased pressures on services as the eligibility criteria effectively lowers the access threshold. Just within Essex, we estimate that the cost of implementing the Care Bill could be in the region of £40 million in year one alone arising from new duties towards carers, the cost of additional assessments, loss of income/client contributions and the new draft eligibility criteria.

1.4 ECC therefore supports the inclusion of an LGA-sponsored clause that seeks certainty on the adequacy of funding. Furthermore, ECC would support independent verification by the Office of Budget Responsibility on an annual basis about the funding requirement for adult social care and support:

1.5 AMENDMENT ONE: FUNDING FOR NEW COSTS ARISING FROM PART 1

To move the following Clause:—

“(1) The Secretary of State must provide local authorities with sufficient funding to enable them to meet new costs arising directly or indirectly to them by virtue of this Part.

(2) The costs mentioned in subsection (1) include (but are not limited to)—

(a) costs of introducing the new measures set out in this Part;

(b) on-going costs of implementing those measures (to be allocated through the annual spending review);

(c) costs identified by the Department of Health to be funded through the Better Care Fund.”

1.6 AMENDMENT TWO: PROVIDING ASSURANCE ON FUNDING

To move the following Clause:—

(1) Before any provision of Part 1 is brought into force, the Joint Care and Support Reform Programme Board must have informed the Secretary of State that it is satisfied that sufficient funding is in place or will be put in place to ensure that the provision in question can be implemented satisfactorily.

(2) In subsection (1), the “Joint Care and Support Reform Programme Board” means the board of that name consisting of representatives including the Local Government Association, the Association.

(3) That the Office for Budget Responsibility includes an annual assessment of funding requirements for care and support within its annual forecasts on public sector finances.

2. The definition of wellbeing (Section 1) and links to the eligibility criteria (Section 13)

2.1 Section 1(2) provides a list of what ‘wellbeing’ may mean in relation to an individual. Essex County Council believes that Section 1(2) should not form part of the primary legislation; rather it should form part of policy guidance on the application of the eligibility criteria (which has still to be finalised).

2.2 ECC believes that Section 1(2) pre-empts the detail of the eligibility criteria, which the Government has indicated will be formally consulted on in May 2014. Section 1(2) could also increase the risk of legal challenge for local authorities as rights under Section 1(2) are judged against eligibility criteria for services.

2.3 ECC therefore supports the deletion of Section 1(2) from the Bill and we believe this is consistent with the conclusions of the Law Commission’s report which stated that while an overarching wellbeing principle would be a positive inclusion, the principle itself should not be prescriptively defined. Any such litigation is likely to be complex and costly to local authorities due to the subjective nature of individual wellbeing in any given social care context.

2.4 The Law Commission stated:

“A primary well-being principle would provide a positive statement about the nature and purpose of adult social care. This principle would operate on two levels. First, when general decisions are being made under the legislation which do not relate directly to an individual (such as when local authorities commission services or set their eligibility criteria), decision makers would be required to ensure that in a broad sense adult social care promotes the well-being of individuals. Second, the principle would also apply when decisions are being made in relation to individuals.

“In both instances, the well-being principle would be worded to operate as a rule which applies to every decision made under the statute. We note that the eligibility decision in relation to an individual
person is not a decision for the purposes of the well-being principle, but rather is part of the process of determining the appropriate well-being of the person concerned.

“The term well-being would not be defined precisely in the legislation. No single definition could offer an exhaustive account of what would promote or contribute to a person’s well-being in any given circumstance covered by the statute; the intention is that the individual person and their circumstances should determine the result. In some instances, the well-being of the individual may best be promoted by the provision of a comprehensive care package; in other cases (for example, where the person falls below the local authority eligibility criteria) wellbeing may best be secured through advice, information and signposting to universal services.”

3. Carrying out of assessments and / or the review of care and support plans (Sections 9, 10, 27 and 78)

3.1 ECC would welcome clarity from the Committee about whether local authorities could delegate responsibilities around the carrying out of assessments for adults and carers (Sections 9 and 10) and carrying out of reviews of support plans (Section 27) to a third party, and whether it is allowable under the criteria for delegation set under Section 78.

3.2 ECC believes that local authorities may need flexibility in this regard in order to be able to cope with the high level of assessments and reviews that may be required. ECC also believes that the Voluntary and Community Sector has an important role to play in supporting the early intervention and prevention agenda with regard to initial assessments and signposting for further information, advice and support.

4. Deferred payments

4.1 ECC believes there is a need for a national body to oversee and administer the deferred payments schemes.

4.2 We therefore support the addition of a clause that has the support of the LGA and CCN (County Councils Network):

4.3 To move the following Clause:—

“(1) The Secretary of State may make arrangements for any person or body specified in the arrangements to exercise on behalf of local authorities, to such extent as is so specified, any function exercisable by local authorities by virtue of regulations under section 34.

(2) Any arrangements made under subsection (1) shall not prevent local authorities from exercising the function in question themselves.

(3) The Secretary of State may pay to any body or person by whom any function is exercisable by virtue of subsection (1)—

(a) such amounts as he considers appropriate for the purpose of meeting expenditure incurred or to be incurred by that body or person by way of administrative expenses in, or in connection with, the exercise of that function;

(b) such remuneration as he may determine.

(4) Any payment under subsection (3)(a) may be made subject to such terms and conditions as the Secretary of State may determine; and any such conditions may in particular—

(a) require the provision of returns or other information before any such payment is made;

(b) relate to the use of the amount paid or require the repayment in specified circumstances of all or part of the amount paid.”

5. The implications on local authorities and on providers of the new cap on care costs (Section 15) and the new duties to set up independent personal budgets and care accounts (Sections 28 and 29)

5.1 ECC seeks clarification from the Bill Committee as to whether the cap on care costs (Section 15) will be applied retrospectively. Will somebody already receiving care be exempt from the cap on care costs?

5.2 The requirement to set up and provide annual statements on independent personal budgets (clause 28) will create an administrative pressure on local authorities. It will also highlight the differential between local authority rates and self-funder rates, which could begin to undermine the business model for many providers. ECC expects that local councils receive full funding under the new burdens doctrine.

5.3 ECC would also like to stress the potential impact on the provider market of Section 28, which states under Section 28 (1) that “an independent personal budget is a statement which specifies what the cost would be to the local authority concerned (see section 24(3)) of meeting the adult’s eligible needs for care and support”.

5.4 As a result of our buying power and economies of scale, an ECC residential placement costs 40% less than the private market rate paid by a self-funder. ECC hourly rates for Home Support Services are about 20% less than self-funders.
5.5 The introduction of the cap and obligations on local authorities to broker or arrange services for self-funders will make it impossible to maintain this differential, because local authorities will have to place self-funders on their residential care contracts. While initially this may have a positive impact for self-funders, this is likely to result in a reduction in providers’ turnover which will not be sustainable long term. There could be an increased risk of provider failure and/or upward pressure on market prices for local authorities as providers seek to sustain their business.

5.6 ECC therefore believes a market assessment is required to understand the implications.

6. Provider failure and oversight of the care market (Section 54)

6.1 The Care Quality Commission (CQC) would gain new duties to oversee the care market, monitor the financial sustainability of providers subject to the regulatory regime, and to inform relevant local authorities is a provider is likely to fail.

6.2 Section 54 suggests that the CQC will not monitor all providers but just those that meet the eligibility criteria.

6.3 ECC seeks clarification from the Bill Committee on who holds responsibility for monitoring the sustainability of those providers that are not subject to CQC oversight?

7. Responsibilities of local authorities towards prisoners and those in bail accommodation (Section 75)

7.1 We would welcome the Bill Committee Members exploring several issues in committee:

(a) How can the local authority meet the wellbeing criteria under Section 1(2) of the Bill (“wellbeing”) for those who are incarcerated?

(b) How can local authorities meet eligible unmet need in a setting where we cannot actually implement the provision required?

(c) How will portability of assessment work within penal establishments?

January 2014

Written evidence submitted by Jon Clift (CB 21)

I am social care lawyer and wish to raise the following issues with Committee members regarding the Care Bill.

The Repeal of Section 21 of the National Assistance Act 1948

Section 21 places a strong duty on local authorities to provide residential accommodation for adults “who by reason of age, illness, disability or any other circumstance are in need of care and attention which is not otherwise available to them”. The Care Bill proposes to repeal section 21. Instead the provision of residential accommodation will be determined by the new eligibility criteria (set at substantial).

However, the Law Commission concluded that if section 21 were repealed in this way certain groups would lose their entitlement to accommodation. In broad terms these groups would be homeless people and asylum seekers who have relatively low level needs for care and attention but do not have access to accommodation in which these needs can be met. Case law has shown that the level of care and attention is very low in such cases where the person does not have proper accommodation or is an asylum seeker. The Commission therefore concluded that section 21 should be retained in the Bill and operate as a long-stop legal duty for those with a need for care and attention who fall below the local authority eligibility criteria (see recommendation 18 of its final report).

The draft regulations on eligibility issued by the Government make no reference to such cases. It is therefore likely that a significant number of vulnerable homeless people and asylum seekers will lose their entitlement to accommodation unless the Government addresses this either by retaining section 21 or adjusting the eligibility criteria regulations.

Section 117 of the Mental Health Act 1983

Section 117 is a strong legal duty to provide after-care services to certain former psychiatric patients. The Care Bill proposes to introduce a definition of after-care services in order to introduce greater clarity about the range of services that can be provided.

However, the Care Bill fails to clarify the relationship between section 117 and the eligibility criteria. The Law Commission raised concerns about the lack of clarity in this area. The central question is whether or not a local authority can apply the eligibility criteria to the provision of section 117 services. The Commission argued that where there is an individual duty to provide services which gives local authorities some discretion to have regard to resources in exercising the duty (such as section 117) it can apply the eligibility criteria (see pp 55 to 56 of its consultation paper).
However, this conclusion was reached based on the existence of statutory guidance setting out the eligibility criteria. Under the Care Bill the eligibility criteria will be set out in regulations. Neither the regulations not the legislation state whether or not the eligibility criteria should apply to section 117.

The legislation needs to make this relationship clear. It needs to specify whether or not the provision of aftercare services should be subject to the new national eligibility criteria.

January 2014

Written evidence submitted by Graham Carey (CB 22)

1. This is a personal submission. I am a retired police superintendent and have been the independent chair of a unitary authority’s multi-agency adult safeguarding board for 5 years. This submission concerns only adult safeguarding and argues for including one further duty on Safeguarding Boards within Schedule 2. That is requirement to produce annually a strategic assessment. I want to suggest that introducing this requirement as a precursor to producing a strategy will provide a catalyst for better partner engagement in the whole process and may lead to the mainstreaming of that proportion of abuse which is crime.

2. There is precedent. Under the Crime and Disorder Act 1998 (S6) multi-agency Crime and Disorder Reduction Partnerships (now Community Safety Partnerships) also have a duty to publish a Strategy but before doing so they have a duty to produce, consult upon locally and publish a strategic assessment on which to base that strategy.

“Before formulating a strategy, the responsible authorities shall carry out, taking due account of the knowledge and experience of persons in the area, a review of the levels and patterns of crime and disorder in the area.... and prepare an analysis of the results of that review and...publish in the area a report of that analysis; and obtain the views on that report of persons or bodies in the area whether by holding public meetings or otherwise”.

3. Health’s Joint Strategic Needs Assessments do not, generally, concern themselves with adult safeguarding nor, again generally, do CSP strategic assessments.

4. This amendment would bring changes beyond producing a more analytic, information based and intelligence led strategy than may otherwise be the case. It makes it more likely that the end result will be a partnership strategy on which local communities have been consulted, rather than an adult social care strategy. It will facilitate developing deliverable strategies for prevention, in which police and community safety partnerships have decades of experience. It will push partners to better engage in information sharing at the strategic level which may influence the significant problem of failing to share information at the operational level.

5. Last, but perhaps of most significance, it would improve police engagement with adult safeguarding which, broadly speaking and with some exceptions, has been patchy. In part this is because they have never had to engage and also because social care may not always view police involvement as appropriate or desirable other than in the most serious cases. Considering that over half of adult safeguarding referrals in England concern physical abuse (assaults), financial abuse (theft or deceptions) and sexual abuse, this is a lot of recordable crime that is not being recorded.

6. The abuse of vulnerable adult data set (AVA) published by NHS Information Centre for Health and Social care provided outcomes for approximately 86,000 completed adult safeguarding referrals 2011/12. There were 18 permissible outcomes for local authorities to record, two of which were police action and criminal prosecution/formal caution. (Police action is not defined). Of the 86,000 completed referrals, police action is shown in 6,045 cases (7%) and criminal prosecution/formal caution in just 1%. The data for 2012/13 is the same. Of approximately 100,000 completed referrals police action was recorded as one of the outcomes in just 5,185 cases and criminal prosecution/formal caution in 1,120 cases. While some “minor” assaults may well fall below the threshold for recording as crime, it is hard to see how financial and sexual abuse is not recordable crime.

7. I am unclear when and why we began to refer to crime against a certain class of victim as abuse rather than call it what it is: assault, rape, theft or deception. It creates a tier of victims who receive a different level of service. It is certainly a barrier to bringing this into the mainstream and it contributes to the accepted deficit of data about crimes against vulnerable and at risk adults.

8. The Law Commission suggest that adult safeguarding interventions should be primarily about resolution rather than prosecution. For most cases the person at the centre of the investigation, the “victim”, ought have the major say in whether or not a police investigation and/or prosecution is desirable or appropriate. In many cases prosecution may well not be desirable, appropriate or in the best interests of the “victim”.

9. For many front line police officers formally reporting a crime is the first step in a process which leads to investigation and prosecution. There have been cases reported where officers have been reluctant to formally record a crime against vulnerable or at risk adults because the victim is deemed from the outset to
be an “unreliable witness”. This is not the view of senior police officers, nor is it the position of the Crown
Prosecution Service, but it does happen.

10. Home Office is quite clear on the requirement on police to record crime in these circumstances.

11. “The requirements on the police to record crime are as set out in the National Crime Recording Standards
(NCRS) and the Home Office Counting Rules (HOCR) for recorded crime. They both take a victim focussed
approach and the general rules apply. The Home Office has made clear that the fact a victim may not wish to
support a later prosecution is not a reason why a crime should not be recorded’. The HOCR General Rules is
accessible via the link HOCR General Rules. Section A, Whether & When to Record (2 of 7) states that:

12. Referrals made by other organisations to the police in cases involving crimes committed against
vulnerable persons should be recorded by the police, regardless of any decision to resolve it by the other
organisation. Where as a result of Multi-Agency Risk Assessment Conference (MARAC) procedures, police
become aware of an allegation of a previously unrecorded notifiable offence they must deal with the recording
of such crime in accordance with NCRS. That is applying the third party reporting criteria, or where they are
not acting for or on behalf of the victim, seeking victim confirmation. The level of any subsequent investigation
remains a matter for the relevant Chief Officer of the force concerned.

“Whilst this section makes specific reference to existing MARAC processes, the same principles
should apply to referrals by other partnership working arrangements”. November 2013.

13. Not all abuse is crime, clearly much is not, but that which is crime should be formally recorded as such.
It is neither feasible nor desirable to compel social care or individuals to report crime to police but I do believe
that a significant increase in reporting would be a consequence of a requirement to produce data for a strategic
assessment.

14. A reasonable argument against this suggestion is that it may it may discourage the reporting of abuse.
This is the same argument that is made for domestic violence which is not something that we now think the
police should not formally record.

January 2014

Written evidence submitted by Prof Ian Judson (CB 23)

Dear Sirs

As a senior health professional I am writing to express my disapproval of Clause 118 in the Care Bill.
This would permit the Secretary of State for Health to override local decisions regarding hospital closures
or department downgrading. Before this government came into power we were promised “no more top down
reorganisation” instead of which we have the Health and Social Care Bill which has effectively destroyed the
NHS as it was and introduced wholesale privatization. We now see the government wishing to be able to ignore
local considerations regarding the configuration of services. I think this wrong-headed and dangerous. Acute
services, as we all recognize, are under severe stress and the main message of the Francis report, which is that
if economic considerations are allowed to predominate the outcome is likely to be poor care, especially if staff
numbers are too low.

We have now suffered many years of “efficiency savings” which is the accepted jargon for fewer staff doing
more work and while we have to acknowledge the difficult financial circumstances we are facing at the moment,
it cannot be right to give the Health Secretary carte blanche to make unilateral decisions in this fashion.

January 2014

Written evidence submitted by The British Medical Association (CB 24)

CARE BILL

House of Commons Committee Stage Briefing

Part 2—CARE STANDARDS

The British Medical Association (BMA) is an independent trade union and voluntary professional association
which represents doctors and medical students from all branches of medicine all over the UK. With a
membership of over 153,000, we promote the medical and allied sciences, seek to maintain the honour and
interests of the medical profession and promote the achievement of high quality healthcare.

Introduction

The BMA welcomed the publication of the Care Bill, recognising that reform of funding for social care and
overhaul of the law underpinning care and support are long overdue. The Bill includes important changes for
the health service, including a number of proposals following the inquiry into failings at Mid Staffordshire Foundation Trust. The Bill also establishes Health Education England (HEE) and the Health Research Authority (HRA) as non-departmental public bodies.

This briefing covers some of the key issues raised by Part 2 of the Bill. Areas of particular interest to the BMA include:

- Duty of candour and wilful neglect
- Performance assessments for hospitals

**PART 2—CARE STANDARDS**

*Duty of candour and wilful neglect*

**Duty of candour**

The Bill introduces a criminal offence for providers that provide false and misleading information about their performance. The BMA supports the principle that NHS providers should be open and honest with patients, and that patients should be placed at the centre of health care.

The BMA strongly supports the principle underlying a duty of candour on individuals and believes all NHS staff must be honest and transparent in everything they do, in order to best serve and protect patients. The BMA also supports the upholding of the highest standards of patient care. We are pleased that the Government has ruled out introducing an individual statutory duty of candour and believe it is unnecessary. Doctors already have a duty to be open and honest with patients about their care through **Good Medical Practice**, the professional code governing their fitness to practise. This requires immediate action where a patient has suffered harm or distress, and an apology and full disclosure about what has happened. It also requires doctors to be honest in their communications with patients at all times, to comply with their employer’s patient safety systems and respond promptly to any concerns about or risks to patient safety. Breaching the code could lead to a doctor’s removal from the medical register and a ban on their ability to practise medicine. An individual statutory duty with criminal sanctions could unintentionally worsen the culture of fear that can already prevent people from speaking out. We strongly believe the Bill does not require any change to introduce a statutory duty for individuals as this would encourage defensive practice rather than a professional commitment to openness and partnership.

There are a number of other ways in which healthcare workers, including doctors, can be prosecuted using both criminal and civil proceedings in connection with dishonest behaviour or action endangering patients.

The BMA opposes amendment 139 which seeks to introduce an individual duty of candour which is unnecessary and could have unintended negative consequences.

**Wilful neglect**

There has been wide discussion about how to ensure greater candour in the NHS. For example, introducing an offence of wilful neglect was recommended in the report from the National Advisory Group on the Safety of Patients in England: A promise to learn— a commitment to act. The recommendation is designed to assure accountability to the patient for egregious acts or omissions that cause death or serious harm, and would introduce legal sanctions in cases where individuals or organisations are unequivocally guilty of wilful or reckless neglect or mistreatment of patients. The Government has indicated that it will look to legislate on this at some point in the future. The BMA recognises the unacceptable failures in patient safety that occurred at Mid Staffordshire Foundation Trust and would wish to engage fully in consultation on proposed measures to avoid this in the future.

**Reviews and performance assessments for hospitals**

The Bill introduces Ofsted-style ratings for hospitals and care homes aimed at facilitating comparison of organisations and services (Clause 89). The BMA supports the intention to review hospital performance, but has concerns that summary score ratings have the potential to reduce a highly complex activity, measuring healthcare performance, to a simplistic and potentially highly misleading measure. Such a measure cannot provide a full reflection of the quality of the numerous complex services assessed, and could only ever be a blunt indicator.

A single organisation can offer a wide variety of different services, and summary scores can mask pockets of poor performance within organisations that are performing well overall. Without wider systems of governance in place, this could have potentially disastrous consequences if underperforming services are overlooked and not addressed. It is important that such ratings are not used in isolation as performance monitoring tools. In addition, this potential loss of detail through combining indices makes it more difficult to identify areas for

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84 House of Commons Hansard, 19 November 2013: Column 1100
85 General Medical Council (2013), Good Medical Practice. Manchester: General Medical Council
improvement. Providers could miss an opportunity to learn from feedback and address quality issues. Similarly, this system could fail to identify good quality services within an overall low scoring provider, where a low score in one area dominates the summary score. This was acknowledged by Sir Bruce Keogh in his letter to the Secretary of State for Health in his review of 14 hospital trusts in England from July 2013: “We found pockets of excellent practice in all 14 of the trusts reviewed. However, we also found significant scope for improvement, with each needing to address an urgent set of actions in order to raise standards of care.”

At the 2013 Care Quality Commission (CQC) accountability hearing with the Health Select Committee, David Prior said that in addition to an overall rating, for large hospitals, “there will also be a rating of the eight core services, which are identified as A and E, maternity, paediatrics and the like. There will also be a rating for whether it is well led and whether there is compassionate, safe, effective care and responsiveness.” We welcome the move to publish performance indicators for individual services provided by service providers, however do still have concerns that summary risk scores will overshadow these scores and distort perceptions of the services provided. The BMA agree with the Health Select Committee who state in their report from the 2013 Accountability Hearing with the CQC, “It is essential that the CQC act quickly to establish public understanding of, and confidence in, the ratings system.”

For many years, the BMA has promoted a focus on clinical outcomes and we believe that, where applicable, this is a more appropriate measure of performance than meeting targets. A summary score rating system risks political interference by enforcing targets that focus on a very narrow remit of provider activity. It is important that the detail of the new system ensures patients are not misled. We agree with the Nuffield Trust that the decision to aggregate scores for hospital sites, and the level of publicity that is likely to surround them, may increase the risk of misleading the public and misidentifying problems. For this reason, it does not seem the most appropriate tool for performance measurement or for incentivising quality improvement. The outcome of the Francis Inquiry highlights the importance of focusing efforts on improving services for patients and not diverting attention to meeting targets. As such, any rating system should not be used to rank organisations. The BMA believes that the CQC inspection judgement should be the most important factor in an organisation’s rating.

The final design of the rating system is being led by the CQC, following consultation. Implementation must be developed carefully and in partnership with all key stakeholders. As recommended by the Nuffield Trust’s independent review, “Rating Providers for Quality: a policy worth pursuing?”21 a system of aggregate ratings requires detailed strategic planning if it is to be credible, sustainable and of use to patients and the public. The review recommended that the development process should be largely “sector-led” and should focus on the medium term (five to ten years) as well as the short term.

We are pleased with the announcement to give the CQC statutory independence and look forward to seeing more of the detail about how this will work in due course.22 Greater independence would help ensure the development and implementation of any ratings system has longevity. We would hope that this freedom would enable the CQC to define more closely which expert organisations and groups should participate in drawing up the indicators. The Nuffield Trust recognised that any new ratings system needs to encompass a transparent system for determining the indicators, and also requires an agreed measure to ensure any disputes about them can be resolved.

The BMA supports amendment 144 which will require the CQC to publish the performance indicators for individual services provided by service providers, providing greater transparency.

January 2014

Written evidence submitted by Staffordshire County Council (CB 25)

Authors: Ben Odams, Public Affairs Officer

Contributors: Martin Samuels Commissioner for Care, Sara Pitt Principal Accountant

Staffordshire County Council recognises the Care Bill as the single biggest adjustment of responsibilities and financing for the care system since a national system was introduced in 1948.

We welcome the opportunity to engage through the committee stages to ensure that the bill reflects the current concerns within local government and can succeed in promoting health and wellbeing, resolving the current problems in the care system and complimenting the work of the County Council in establishing a commissioning based approach that promotes independence, choice and control for those in the care system.

ABOUt StafforDshIre

Staffordshire County Council has transformed to become focused on outcomes, using innovation, insight and smarter use of resources, commissioning and procurement to meet future challenges in the public sector. This transformation is outlined in the council’s strategy entitled ‘Achieving Excellence’ which is a single vision to establish a “connected Staffordshire, where everyone has the opportunity to prosper, be healthy and happy”. This vision is matched by organisational values and behaviours, which are in turn expressed through three key outcomes:

1. Be able to access more good jobs and feel the benefits of economic growth
2. Be healthier and more independent
3. Feel safer, happier and more supported in and by their community

In meeting these outcomes, the council is committed to challenging organisational assumptions and boundaries. We believe we have to work much more closely with partners, residents and communities to ensure the £7.5billion spent by the public sector in Staffordshire each year is used to maximum effect. We believe that by emphasising partnerships and outcomes we can ensure that each public sector partner focuses on doing and delivering on what they do best, with the whole achieving more than the sum of the parts.

Our vision involves looking at the fundamental role of the council and its partners in people’s lives now, and looking at how that role could develop in future years, when the impact of technology and societal change are considered. For Staffordshire County Council, our strategic strengths in developing an overview and insight of need within the county are matched by our ability to commission the best providers to deliver our outcomes.

OveRvIew oF the BIll

Staffordshire County Council believes that the bill presents a welcome opportunity to update Social Care but some significant challenges remain. These challenges are not necessarily negatives, but in conjunction with areas of concern below, the challenge will be to ascertain how these could be implemented with a Strategic commissioning system. Our overriding aim is to ensure that the development of a modern Care System doesn’t create an extra burden on the system and doesn’t undermine an approach to commissioning.

We have read with interest the work of the Kings Fund on this, including the recent blog article93 that covered in detail the different attitudes towards the role of the government and the state. We find that the expectation that ‘the government’ in its broadest sense should provide the care with varying degrees of individual responsibility. However, this should not be the basis of creating an additional burden on local authorities that is prescriptive—the simple logic being that whilst the role of the state should be set in statute it should not undermine local reforms and services that exist.

Furthermore it is critical that the Bill reflects the need to build into the system an expectation of self-reliance, independence and choice. This is crucial to support the change in culture that will be required to ensure that the system can support future developments and demands without creating expectations on the system that cannot be met.

The changes to the eligibility criteria to support the underpinning principles in the Bill therefore must promote independence, and to avoid creating an entitlement culture. We are concerned that the development of new criteria would necessitate a large scale reassessment of needs with current users and could create an excessive demand early on in the transition of the system.

RegulAtIons

The Care Bill will require detailed regulations, guidance and supplementary legislation so that councils can commence their local preparations. However it is essential that local authorities are included in the drafting of thee as well as being able to respond to the consultation on them. We recognise that the LGA is also calling for this and it should be noted that with different local authorities we cannot have a top-down set of regulations that assumes the uniform delivery of services, and isn’t flexible to changes in provision. We favour the maximum level of local discretion and would feel that national regulations and guidance should not be onerous to either compliance or implementation of the reforms.

In particular there is a concern regarding regulations and the statutory duty placed on Health Wellbeing Boars by s195 of the Health & Social Care Act 2012 to encourage greater use of arrangements under s75 of the NHS Act 2006. This is also in line with the philosophy behind the Better Care Fund, which will require a major extension of s75 arrangements in Staffordshire.

The problem is that the regulations need to recognise that contracts and agreements are based around financial years—so the development of regulations needs to reflect those timescales to ensure that enhanced provision as a consequence of the Bill’s passage supports local commissioning cycles.

93 ‘Who should pay for care services’ 13th January 2014 http://www.kingsfund.org.uk/blog/2014/01/who-should-pay-social-care-services
Clauses:

— The wellbeing principle set out on the face of the Bill. (Clause 1& 2)

Staffordshire County Council, like most local authorities, is already fully engaged in promoting individual health and wellbeing. Indeed the Health & Wellbeing Board’s strategy makes it clear that the prevention, early intervention and community based approaches are key to meeting our outcomes and objectives.

We welcome the current wording of clause 1 in part because it preserves the high level of local discretion needed to meet those general responsibilities.

Additionally Clause 2 does support a commissioning based approach; however the committee may want to be assured that the provisions within the Clause are not undermined by the expectations created by the changes to the eligibility thresholds. The overall balance of the legislation stems from the ability of the local authority to promote individual choice, independence and reliance to delay the need for support. This isn’t about reducing entitlement but ensuring the resources available are utilised to the maximum effect for those who do meet the necessary criteria.

However it may be effective to demonstrate the approaches for provision, including direct delivery, commissioning and mutualisation within clause 2.

— The focus on the importance of integration between health and care. (Clause 3)

Staffordshire County Council welcomes the provisions for a more integrated care system. We value the role of creating an integrated system for supporting both health and care due in part to the longstanding impact of morbidity on the system.

However we are concerned that Clause 3 does not clarify what powers the local authority has to support integration. This could therefore delay the creation of a more integrated local structure which could be further delayed as the NHS pursues its efficiency agenda under the Nicholson challenge.

More widely, the issue of funding is something that needs to be addressed within the Clause. Whilst we anticipate that supplementary legislation and regulations will be central to implementation of the Care Bill, there is a need to establish the various funding mechanisms the government anticipates and expects to be applied in terms in the medium to long term. This should also reflect the expected balance between NHS resources and the LA.

As the King’s Fund and other commentators have suggested the biggest challenge is getting more resources into the system, firstly to balance out the integration between the NHS and Local Authorities but, secondly to address systemic shortfalls present within the current system which will remain through the implementation of the Care Bill. Whilst the Better Care Fund establishes a common pot in the short term, the longer term would need to be addressed.

Broadly we would assume that this would be subject to local partnership arrangements, however Clause 3 is an opportunity to set out an expectation upon local partners to pool resources to facilitate longer term integration.

— Clause 4: A requirement to promote information and guidance, ensuring people have a better understanding of both ‘the system’ in order to plan for their own future, and how to get help when needed.

Whilst Staffordshire County Council’s current approach relates strongly to the provision of information and guidance to promote personal choice and responsibility around care, the Care Bill and the practicalities of its introduction must address the potential risks around the Local Authority providing/ promoting financial advice/products, legal advice and insurance which future service users may need

Acting as a ‘signpost’ for service users could bring its own challenges in the wake of various ‘mis-selling’ scandals that have struck within the UK. This means that there is a need to ensure that the expectation upon local councils to promote health and wellbeing can be fulfilled by empowering people to make provision for their own care in future years, without that signposting making the LA liable.

As it currently stands Clause 4 section 2 (d) does allow the LA to promote access to independent financial advice, however there is need to ensure that the LA is protected from any future legal action if subsequently that financial advice is unsound.

This is logical primarily because the wider revamping of eligibility criteria and approach to assessments means that local areas will need a variety of options to advise and support local people. The best means to do that is to promote a variety of providers. However such a change within the clause should also bar the local authority from receiving any compensatory arrangements to promote particular advice or information.

— Clause 9—12 Assessment: Overall we believe that Clause 12 needs an additional sub-section to facilitate the ability of local authorities to seek partners to contract out or mutualise their assessment functions. This approach has been undertaken by SCC through our Families First programme and we
have worked closely with government (specifically DfE) to get such innovation supported through the Children and Families Bill.

Being able to use such a mechanism, will not reduce the LA’s responsibility but facilitate the development of services and approaches locally—as we have stated, the Care Bill must support local discretion to support the best outcomes for care users and this change would be welcomed.

Additionally the provisions with Clauses 28—29 have the potential to increase the expected number of ‘speculative’ assessments required by current self-funders who may believe that their prior expenditure counts towards a cap and therefore a presumed expectation of the local authority footing the bill. We believe that either through regulation or clarification, it should be clarified the circumstances under which current service users can be reassessed.

— Clauses 28/29 regarding Individual Personal Budgets and Care Accounts, the role of top-fees and the differential impact on self-funders, Council funded and ‘top-up’ funders.

Overall we welcome the provisions for Individual Personal Budgets and Care Accounts. However we do have some concerns; firstly in a renewed tension between self-funders and local authority funders in terms of the ‘usual cost’ approach which will place more reliance upon ‘top-up’ fees.

This matter has been detailed by Independent Age in their report ‘Short Changed: The Care Bill, top-ups and the emerging crisis in residential care funding’. Although strikingly titled, the report does highlight the disparity between the impact on different service users and we would urge the committee to look into this report.

More widely the difference between the market rate and the local authority rate for care needs to be clarified through the bill and subsequent regulations. The current ability of the LA to limit the costs of care through their own defined rate will be challenged through the development of the care bill and the potential increase in pressure to pay a market rate.

— Deferred Payment Scheme Clause 35

Furthermore, we have serious concerns about the operation of the ‘Universal Deferred Payment’ scheme. Whilst the principle is sound, it presents a challenge for local authorities around the following:

— Cash flow—if deferred payments schemes are used this, in conjunction with a general reduction in charge income, could present a challenge for Local Authorities in terms of covering the cost of care,

— Property valuation and maintenance—whilst the scheme would provide assurance for service users, the methodology and mechanics of valuing the property as part of the assessment process, plus the requirements for maintaining the property will be problematic.

— Variance in valuation—the largest problems concerns how the deferred scheme would accommodate the variation in property values, either in the sense of the property value increasing and how this is reflected in the settling of the deferred payment and secondly how any decline in property values would be resolved.

— Market rates for residential care—as an extension to our comments for Clauses 28/29 there is a concern around the differential for market rates for care versus the current spend by LA’s. This could affect a lot of the calculations for deferred payment and could lead to challenge on the process.

January 2014

Written evidence submitted from Unite the Union (CB 26)

RE. CHAPTER 4, CLAUSE 118 OF THE CARE BILL

I am writing to you to raise urgent concerns about regulations Chapter 4, Clause 118 of the Care Bill.

Clause 118 appears to have been inserted into the Bill as a way to make it possible, easier and faster to close or privatise any viable hospitals. The Government will be allowed to close or downgrade any hospital in the country, with little consultation with local people or regard to clinical need, clinical infrastructure, local clinical expertise or decision making if there is another Trust in financial difficulties anywhere nearby. Given the reorganisations, cuts, and disruption currently being imposed on the NHS, there will be very few hospitals in the country that are not near a hospital that is experiencing financial challenges.

Unite is extremely concerned about the clinical risk caused by these changes and the lack of local control and clinical decision making that will result.

Currently the law allows these fast-track closures to happen only at hospitals that are in such serious financial or clinical difficulties that they are taken into ‘Administration’. Clause 118 however extends the powers of Trust Special Administrator (TSA) that take over struggling Trusts. Crucially these will now be able to take decisions to fast-track the closure of hospitals in another area—no matter how ‘successful’ those hospitals are at addressing the clinical needs of the local population—using the ‘unsustainable provider’ legislation that was
designed only for insolvent Trusts. If it becomes law, this Clause means that no hospital will be safe, no matter how successful, and officials that are distant from the needs of local populations making decisions over the heads of local clinical experts.

Unite believes that this is a dangerous move which will put thousands of lives at risk, by removing local clinical decision making about local NHS provision. Fundamental to the planning of NHS services must be regard to the clinical needs of the communities that are served. Government is not in a position to arbitrarily make these decisions, and must seek proper consultation from local clinicians and the local population.

As it stands it appears that the Government is planning to use the fast track ‘failure regime’ as a tool to reconfigure hospital provision more generally. This is totally inappropriate. If services need redesigning the law must ensure this is with proper and extensive consultation with local people and that decisions are based on clinical needs not political interference.

Evidence demonstrates that clinical reorganisation has a bearing on the immediate and wider population, and ensuring that the distribution of clinical specialisms is a matter of local and regional clinical interest, for example the London Stroke Plan. It is also essential that any reorganisation doesn’t just focus on acute services, but there is also an impact assessment on primary care.

Unite is also extremely concerned about the motivation for introducing this clause, as it appears to be solely aimed at overturning the outcome of the affective local campaign to defend Lewisham Hospital in South London. This campaign successfully took a legal challenge against the Secretary of State to prevent the fast-track closure of Lewisham’s A&E and maternity services, in order to redirect patients (and money) to a different Hospital Trust that had large Private Finance Initiative debts to pay off to the banks.

The clinical evidence demonstrated that these reforms would have been detrimental to the local population and would have put lives at risk. The capacity of neighbouring hospitals was also severely challenged at being able to deliver safe, timely and appropriate services, including in the field of emergency medicine.

After losing both the judicial review and the appeal, the Secretary of State has responded by inserting Clause 118 into the Care Bill as an amendment. It has no relation to any of the other issues covered by the substantive Bill.

Unite believes that this will drastically reduce the rights of the public to have a say in decisions about our local hospital and health provision. These changes make a mockery of the Government promise that in the NHS there would be ‘no decision about me, without me’ and the localism agenda.

Unite urges the committee to urgently move to remove this clause in its entirety from the Care Bill as it offers no benefit to our health service, communities or governance. Unite recognises the need for proper debate on clinical reorganisation to improve the effectiveness of clinical care and to improve the life chances of local populations, however Unite believes that this needs a far greater debate and must be clinically led.

January 2014

Written evidence submitted by the Social Landlords Crime and Nuisance Group (CB 27)

1. INTRODUCTION

1.1 We, the Social Landlords Crime and Nuisance Group (SLCNG) are a national membership body of around 300 registered providers of social housing. Formed in 1995, our members manage around 75% of the nation’s social housing (over 3 million homes).

1.2 Protecting people from harm is central to our purpose and within this our members take their Safeguarding obligations and responsibilities very seriously.

1.3 This submission makes the case for amending the Care Bill to require representation of housing providers on Safeguarding Adults Boards (SABs).

2. WHY HOUSING PROVIDERS’ SHOULD BE INCLUDED ON SABs

2.1 Earlier in the passage of the Care Bill a recommendation that housing providers should be included in the list of statutory members of SABs was not pursued. The Government stated in their response to the recommendations of the Joint Committee on the draft Care and Support Bill that ‘We have intentionally restricted core statutory membership to a few core public bodies, leaving local areas with maximum flexibility whilst securing the statutory position of adult safeguarding. We anticipate and expect membership to be far wider. We would be most concerned if SABs did not address the role, contribution and responsibilities of housing providers in adult safeguarding. We would also expect SABs to draw on the housing sector for input, collaboration and advice. Government will not dictate how this happens, as this will depend on local circumstances, which vary widely across the country. For example, in some areas the SAB may operate sub-groups, including one devoted to housing-related issues that reports back to the main Board’
2.2 Whilst recognising that there are many examples of effective practice, the reality is that issues around information sharing and partner agencies’ engagement stubbornly persist. The July 2013 report Multi-Agency Working and Information Sharing Project- Early Findings identified multiple barriers to further progress.

2.3 That same report found that some areas cited a lack of engagement from their housing partners as a barrier to setting up their multi-agency working and information sharing approaches. Ironically, this is a point that is made in reverse by housing providers in several areas who report that they “struggle” for inclusion in local partnerships despite their proactive approaches to the relevant authorities.

2.4 The difficulties around housing providers’ inclusion/engagement are arguably experienced most acutely in relation to non-local authority housing providers (principally housing associations). In this context it is important to recognise that a majority of the nation’s social housing stock now managed by ‘private registered providers’ (housing associations) whose role and the huge contribution they make is too often misunderstood.

2.5 The difficulty of communicating with adult social care staff, for example, is articulated by one experienced professional as follows: “A particular bug bear is their not infrequent refusal to share information or to include housing staff in multi-agency strategy meetings, justified by the view that they are not deemed to be in ‘the circle of trust’.”

2.6 It is evident from official reports and individuals’ experiences that there is a longstanding impasse which, while it persists, means that the real losers are the vulnerable service users.

2.7 Put simply, anticipation and expectation in relation to housing providers’ inclusion in SAB arrangements is insufficient to deliver the consistency of practice needed across all areas.

3. Benefits of Housing Providers’ Inclusion

3.1 Housing providers’ representation on SABs would

— encourage greater leadership and involvement by housing staff in adult safeguarding
— improve the quality of Serious Case Reviews/Safeguarding Adults Reviews
— contribute to wider agendas including prevention and awareness raising, domestic abuse, crime, hate crime, self-neglect, hoarding, anti-social behaviour, poverty
— reach into local communities, address professional boundaries, reinforce that safeguarding is everyone’s business, contribute funding, involve housing in the development of policy
— improve joint working between housing and adult social care.

4. Disbenefits of continued non-inclusion of Housing Providers’

4.1 Too often, housing providers are seen as the “poor relation” when it comes to safeguarding issues. SLCNG members have experiences where a safeguarding meeting, for example, has been held about one of their tenants, but they have not been invited as they were not seen to be essential partners. Apart from the obvious health and safety risks this may pose to their staff, the safeguarding team were denied knowledge held by the housing provider.

4.2 Housing forms a central and crucial part of a person’s life and housing providers play an essential part in ensuring the wellbeing of tenants and their families. Similarly, housing forms an essential part of the support package for all vulnerable adults and helps to sustain them living in the community.

4.3 SLCNG members are increasingly housing more and more people who have a range of issues making them vulnerable to exploitation and/or abuse in some instances, such as having their tenancies ‘taken over’ by drug dealers.

4.4 There are many instances where housing providers have found it difficult to get other support services to engage until they are at the point of eviction or other legal action. Such situations are both wasteful of the resources of all organisations involved and a cause of avoidable anxiety to individuals involved.

4.5 A requirement to include housing providers in SABs would significantly reduce or remove the risk of such instances recurring in the future.

5. Logistical Issues and Overcoming Them

5.1 Arguments put forward against housing providers’ representation on SABs frequently cite the view that there are just too many providers in an area (there could be dozens) to make inclusion manageable.

5.2 This is not sufficient reason to abandon or forego the benefits of including housing providers. Many areas have resolved the same logistical issues in relation to housing providers’ involvement in Community Safety Partnerships, for example, via the operation of a collective or consortium approach. The same or similar approaches could be applied equally well to SABs.

6. Conclusion

6.1 ‘The role of housing in preventing and addressing adult abuse is neglected in legislation, policy, practice and research’ (Joint Committee on the Draft Care and Support Bill, 2013, para.163, p.42).

6.2 The inclusion in the Care Bill of a Clause requiring housing providers’ representation on SABs would address not only the first of these neglected areas (legislation) but would also improve policy and practice.

January 2014

Written evidence submitted by the Chartered Institute of Housing (CB 28)

1. General comments

1.1 CIH welcomes the Care Bill and the drive towards more effective integration of care, support and health services to deliver better outcomes of health and wellbeing for individuals.

1.2 We fully support the aim to increase a shift to prevention/delay and reduction of higher care needs and prevention of ill health, through better integration. We acknowledge the increased focus on housing and its importance in achieving the aims of the Bill, through:

— Inclusion of suitability of accommodation in the wellbeing definition
— The explicit reference to housing as health-related service provision
— Inclusion of district authorities in two tier areas, and of private registered providers of housing in the general duty to cooperate.

2. Risks to effective integration with housing

2.1 However, we remain concerned that the delivery of the important ambitions of the Care Bill will be compromised by the lack of integration with housing services, and a failure to capitalise on the demonstrable effectiveness of decent, affordable, accessible housing and related support services to achieve this.

2.2 To support housing organisations partner effectively with health and care, CIH and Housing LIN developed a framework focused around the outcomes set for health, public health and social care; we are committed to supporting housing professionals engage with this critical agenda.

Safeguarding

2.3 CIH remains concerned about the lack of explicit reference to local housing authorities and providers as partners for Safeguarding Adult Boards (clause 43 and schedule 2), although we acknowledge the general duty of cooperation in clause 6.

2.4 We have developed work to support housing to engage effectively as partners around the safeguarding agenda, following on from an article by Imogen Parry in CIH’s key publication (Learning today, leading tomorrow).

2.5 Local housing authorities’ role in coordinating wider relationships with housing and support providers, and with local private sector landlords, can play a pivotal role in supporting protocols and procedures to support wider engagement in safeguarding locally. The increasing vulnerability of many tenants of council/ALMO and housing associations, in general needs homes as well as specialist accommodation, makes them critical partners in identifying people potentially at risk and enabling a proactive approach to maintaining people’s safety.

Cross funding

2.6 We are concerned that a strict reading of clause 23, prohibiting cross funding of other housing services (under the Housing Act 1996) may lead to retrenchment from joint commissioning of housing support services and disabled facilities grants (which remain mandatory for local housing authorities), in spite of the understanding of ‘health—related services’ (referred to in clause 3) as inclusive of housing. Again we would welcome the opportunity to work with the department on guidance on this matter, if clarification on the face of the Bill is not possible.

3. Further opportunities for integration

3.1 We believe that further opportunities for integration could be strengthened on the face of the Bill by explicit reference to housing services in respect of the following:

The importance of housing in preventing the need for care and support (clause 2) to achieve a shift of focus on commissioning for prevention.

3.2 Delivery of a full range of preventative and integrated services in a local area will require mechanisms for local housing authorities and housing providers to facilitate, identify and deliver home based solutions to meet individual and community care and health needs.
3.3 Local health bodies, social service and authorities, and housing providers should work together to understand where costs build up in different parts of the care and health system, and to recognise the value of safe, accessible, affordable and settled homes, housing-related support and home-based care services across primary and secondary care. This includes working together to identify the need for specialist and accessible/adapted housing. This could help to reduce the pressure on local hospitals and residential care which are often accommodating older people who would be happier and healthier in their own, independent but supported homes.

3.4 Engagement with housing should take place through health and wellbeing boards, local strategies, and needs assessments across housing, care and health, and directing local commissioning plans. As the Health and Social Care Act 2012 does not provide a specific framework for housing to engage with health, and vice versa, housing authorities and housing providers are struggling to engage with the new local structures. The Care Bill provides an opportunity to resolve this.

The inclusion of housing options in the advice and information provided by local authorities (clause 4).

3.5 Information and advice services across housing, health and care should ensure that individuals in need of care are aware of housing options and housing-based services as part of the local care market. The draft Bill places duties on adult social services and local housing authorities to work together; ensuring that housing options are included in information and advice on care and support is a sensible extension of this.

3.6 Valuable resources already exist in relation to housing and care (run by the Elderly Accommodation Council), including a telephone information line—FirstStop—for older people. This and other resources should be considered in any ways to take forward and develop information and advice. FirstStop has enabled a more integrated local approach in some local authority areas, whereby a number of local partners utilise the national resource provided by FirstStop in their own local areas. This could be a useful model for local authorities when developing information and advice available locally as part of responses to the Bill. Social housing providers deliver a range of advice and information services to their tenants and, in some areas, to people across housing tenures in their localities. There should be a clear link between, and signposting across, the services to enable people to understand the range of options available for meeting their needs, particularly at early stages to prevent/delay increased needs for care.

The inclusion of housing in assessments for care and support needs, and referral to the relevant local authorities where housing issues/solutions are identified (clause 9) and particularly on discharge from hospital needs (schedule 3).

3.7 Integrated working between housing, care and, where appropriate, health (for hospital discharge) is key to safe and effective delivery of care, and timely hospital discharge, and to ensure that the ‘suitability of living accommodation’ or home environment is recognised.

3.8 The recognition of the critical impact of the home for achieving this led to a hospital2home resource pack developed for the different groups of professionals involved, by leading experts across the health, care and housing sectors. A number of highly successful rapid response schemes by Home Improvement Agencies have developed in different localities as a result.

About CIH

CIH is the professional body for people working in housing. Many of our 22,000 members deliver housing management and support services to people who require care and support, both in general and specialist housing environments. For many others, housing support services make a significant contribution to preventing the need for more intensive care provision, by helping people to manage and maintain their homes and tenancies, access volunteering opportunities, and supporting people into employment, education or training—all of which are major contributors to greater health and wellbeing.

CIH’s Director of Health and Wellbeing, Domini Gunn, gave oral evidence to the Joint Committee on the early draft of the Bill, and at the Committee’s request we provided additional written evidence.

www.cih.org
January 2014

Written evidence submitted from Colin Slasberg (CB 29)

The Bill as it stands contains what is surely a contradiction and one that will create confusion if not resolved before finalisation. It is in relation to the issue of responsibility for making decisions about how eligible needs will be met.

Section 24 (1) (c) says that the local authority must ‘help the adult with deciding how to have the needs met’. There is no references to the status of the local authority’s help, thus allowing for the adult to ignore it. This clearly conveys the message that the responsibility for decision remains with the adult, not the local authority. However, section 25 (5) says that ‘the local authority must take all reasonable steps to reach agreement with
the adult or carer for whom the plan is being prepared about how the authority should meet the needs in question'. This conveys the message that the responsibility remains with the local authority, not the adult.

It is the message in 25(5) that should prevail. It surely cannot be the intention of Parliament to commit local authorities to decisions that may commit a higher level of spend to meet needs than would be possible by other decisions, or to spend public money on a resource that the authority does not believe will meet the assessed needs. Therefore, 24(1)(c) should be amended to say something like 'agree with the adult how the needs should be met'.

January 2014

Supplementary written evidence submitted by the British Medical Association (CB 30)

PART 3—HEALTH

The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine all over the UK. With a membership of over 153,000, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

Introduction

The BMA welcomed the publication of the Care Bill, recognising that reform of funding for social care and overhaul of the law underpinning care and support are long overdue. The Bill includes important changes for the health service, including a number of proposals following the inquiry into failings at Mid Staffordshire Foundation Trust. The Bill also establishes Health Education England (HEE) and the Health Research Authority (HRA) as non-departmental public bodies.

The BMA raised issues with some aspects of the Bill as it progressed through the House of Lords, particularly around long term workforce planning for HEE, and reviews and performance assessments for hospitals. Whilst we are encouraged by some of the responses the Government gave to a number of our concerns—particularly on education and training—we still feel that the legislation should be tightened to explicitly reflect assurances given.

During Report Stage in the House of Lords, the Government also introduced amendments to the powers of a Trust Special Administrator (TSA) as part of the failure regime process. These would enable the TSA to make changes in another local trust not involved in the failure regime. The BMA has concerns about the scope of these powers.

This briefing covers some of the key issues raised by Part 3 of the Bill. Areas of particular interest to the BMA include:

— Long term workforce planning
— Trust Special Administrator

PART 3—HEALTH

Long term workforce planning

National planning of the health care workforce

HEE’s responsibility for workforce planning must be strengthened in the legislation to mitigate against risks of oversupply of health care workers, as well as national or local shortfalls. HEE should be required to plan the health care workforce in accordance with national and local needs, whilst taking into account workforce needs in Wales, Scotland and Northern Ireland as the workforces heavily co-mingle. In doing so, the BMA believes that HEE must be required, as much as possible, to match the number of trained health care workers to national and local need over a long timeframe.

The Bill provides for “long term” workforce planning (Clause 98(5)), but the BMA believes that the length of time should be more explicit than the phrase “longer term”. The maximum planned duration of post graduate training for a doctor is 10 years, and therefore an explicit term of planning similar to this is preferable.

HEE’s Strategic Intent document does include a commitment to ensure a strategic direction for a long term period of “10–15 years”. The BMA is pleased with the Government and HEE’s stated intention in this regard, but in order to ensure that workforce planning takes a realistic shape in correlation with the changing demographic and service needs, we believe that this should be enshrined in legislation.
The Shape of Training Report\(^5\) called for doctors to be trained in a shorter timeframe with a focus on obtaining more general skills. It recommended that significant elements of specialty training should be moved to post-training “credentials” that are outside of a formal training structure and are acquired according to local patient and workforce need. We understand the aim is to create a trained workforce that is more receptive to future demographic change. However, we are concerned that limiting the acquisition of highly specialised skills to local requirement will instead create a workforce that merely reacts to change rather than pre-empts it. We do not believe that wholesale change to the postgraduate medical training structure is required to create a more flexible workforce. Work is ongoing to identify transferable competences that will enable trainee doctors to change specialties more easily and therefore train more flexibly. Updates should be made to specialty curricula based on forecasts for workforce planning over a longer period to ensure that supply is matched to demand and curricula can be updated accordingly without expensive and unnecessary overhaul.

The BMA supports amendment 162, specifically parts (4) and (5) which requires HEE to ensure that the number of skilled healthcare workers matches the health service needs. However we would like the intended meaning of ‘long-term’ to be set out in primary or secondary legislation to prevent ambiguity.

Advice

Clause 100 sets out the bodies or persons that HEE both “must”, under section (2), and “may”, under section (3), seek advice from who are involved in or who otherwise have an interest in the provision of education and training for healthcare workers.

Two of HEE’s main functions are to bring together the interests of key groups to oversee the shape and development of the public health and health care workforce, and to ensure the delivery of excellent education.\(^6\) Health care workers in training on the frontline are uniquely placed to determine whether the training they receive is sufficiently responsive to the changing needs of patients and local communities. For HEE to carry out its functions effectively, the BMA would like provision within the Bill to require HEE to consult health care workers who receive education and training, or representatives of those health care workers, in addition to those groups outlined in section (2).

The BMA supports amendment 166 which requires HEE to seek advice from professional bodies, royal colleges, trade unions, commissioners and patients’ groups.

Trust Special Administrator

During the later stages of the Bill’s progress through the House of Lords, the Government introduced a new clause (Clause 118) regarding the trust special administration process which occurs as part of the failure regime.\(^7\) The new clause provides that a trust special administrator may decide to take action in relation to a failing NHS trust or foundation trust that has direct impact on another NHS or Foundation Trust. Essentially, a trust special administrator will be able to make changes to facilities and services in another nearby NHS or Foundation Trust as part of the remedy to address failures in the NHS or Foundation Trust being addressed.

The new clause extends the period for the administrator to produce their report from 45 to 65 days. However, there is no provision in the new clause that requires the administrator to consult with patients, public, clinicians, clinical commissioning groups (CCGs) or providers in the area of the other NHS or Foundation Trust. These powers could allow the Secretary of State to use the failure regime to bypass the reconfiguration process and redesign services in a particular area without any input from clinicians, commissioners or the public. The reconfiguration process involves a much more substantial consultation of stakeholders in an affected area and Clause 118 effectively bypasses this and follows a much lower standard of consultation in achieving redesign of services in nearby trusts. Failure to engage with key local stakeholders could have very serious, negative consequences for the proper planning of local healthcare services.

Clause 118 also introduces statutory oversight of CCGs and NHS Foundation Trusts directly to the Secretary of State. This means that these bodies will not have independence from ministerial interference if they, or a provider near them, enters the failure regime. This would undermine the role and ability of a CCG to shape services through commissioning, and may potentially not be able to protect commissioner requested services\(^8\) where a Trust near to that CCG has entered the failure regime.

The clause as it stands could become an avenue for “backdoor” reconfiguration being allowed as part of the failure regime. This clause was introduced without full consultation and has significant implications, which have not been thought through. The Government has brought forward amendments to Clause 118 (amendments 135, 136, 137, 138) which extends the consultation provisions in the current failure regime to other provider trusts, their staff and commissioners affected by the TSA’s draft recommendations where they relate to other provider trusts. In 2012 the BMA outlined clear principles for reconfiguration\(^9\) and we believe that the spirit of

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\(^5\) http://www.shapeoftraining.co.uk/reviewsofar/1788.asp


\(^7\) House of Lords Hansard, 21 Oct 2013 : Column 786

\(^8\) Commissioner Requested Services are a designated range of services that local commissioners believe should be provided locally if any individual provider is at risk of failing financially.

\(^9\) British Medical Association, April 2012 Engaging in local healthcare developments
these principles should be reflected in clause 118. This is why we called on the Government to bring forward amendments to this effect, alongside the NHS Confederation, Foundation Trust Network, Royal College of Physicians and Academy of Medical Royal Colleges.

The BMA broadly views amendments 135, 136, 137, 138 as steps in the right direction. The amendments extend the consultation process required to be undertaken by a Trust Special Administrator where their draft recommendations relate to another trust but we seek clarity and firm assurances from the Government on aspects of that process.

Transparency of consultation

Amendment 135 extends Section 65F in the NHS Act 2006 to ensure that commissioners in other trusts affected by the recommendations of the administrator are consulted in the same way as commissioners in the trust subject to the failure regime process. The BMA supports the principle of this amendment as it is essential that commissioners in areas affected are involved in the process.

However, we have some concerns about the transparency of the outcome of the consultation process. Amendment 135 is explicit that a commissioner in an affected trust is subject to the same procedures as a commissioner in the trust subject to the failure regime. Therefore, as set out in Section 65F(5) of the NHS Act 2006, for the administrator to provide the draft report to the regulator (the Secretary of State), they must obtain from each commissioner a statement that they consider the recommendation would achieve the object of the administration process as set out in Section 65DA of that Act. If the administrator cannot get a statement to that effect from one or more of the commissioners, NHS England must make a statement that they consider the recommendation meets the objective of the process. Where NHS England decides not to provide an administrator with a statement to that effect, they must give notice to the administrator and the regulator with the reasons for that decision. These must also be published and laid before parliament. If NHS England chose to provide a statement where a commissioner has not provided one, there is no requirement to alert the regulator to the reasons why the commissioner does not support the recommendations.

Local consultation

Amendment 170 also extends the requirement to consult to include “any person to which an affected trust provides goods or services”. This would include patients and members of the public in the local health economy. Whilst the current legislation for the TSA process does not extend to requiring patients and the public to be consulted, the BMA notes that in practice, this is an important part of the consultation process to ensure a successful outcome. The BMA supports the inclusion of patients and the public in the TSA consultation process. It is important that those affected are properly consulted with as part of the trust special administration process and that their views are properly sought and considered.

The BMA supports amendment 170 which requires a trust special administrator to have reasonably sought and considered responses from the affected trusts and their staff.

January 2014

Written evidence submitted by the Civil Service Pensioners Alliance (CB 31)

Dear Sirs,

I am writing on behalf of the Civil Service Pensioners Alliance (CSPA)

The Civil Service Pensioner’s Alliance (CSPA) has around 60,000 members and represents the interests of retired Civil Servants, Public Sector Workers and Older People.

We have watched the progress of the Care Bill with interest and there are many good ideas that could be beneficial given the right resources, advice and support. However, there is equally confusion on how the new system will operate, how it will be funded, and if it will really deliver the joined up, whole person care that we all hope for.

This morning I took a call from one of our members who spoke at length about the difficult situation he finds himself in. I think that this may be useful evidence for you to keep in mind about how the system currently impacts on real people.

Our member, who is 88 years old, contacted CSPA about his wife who is 94 and in hospital with multiple health problems. He wanted her to be discharged into a residential care home and had requested this.

After many years of managing at home with a Carer that he pays for himself, his own health means that he is no longer able to cope with looking after his wife. However, he is being pressured to have her returned home by the hospital, which states that she is fit to leave.

Our member is aware that he will not qualify for means tested assistance with residential care costs and is willing to pay. But has had a phone call from Social Services to say that they will not agree to placing his wife, citing that they would then become responsible for the costs of his wife’s care when he ran out of money.
Our member has a supportive GP who has volunteered to speak to the Social Services to make clear that his patient is no longer capable for looking after his wife. At the time of the conversation the GP had not heard from Social Services.

This is only one case of the many that are happening on a daily basis, where the system is going terribly wrong for many older people with a sense of duty to care for their partner or spouse for as long as they are physically able. When they can no longer do this they find that they are cast adrift without support and met with brick walls and “hardened attitudes” from fund-starved service providers.

We remain concerned that this problem is only set to get worse with the ageing population. I hope this case illustrates that those that are able to fund care themselves are also experiencing an unacceptable lack of support.

January 2014

Written evidence submitted from Craegmoor (CB 32)

SUMMARY

— Craegmoor is the UK’s leading independent provider of support for people with learning disabilities, autism, complex needs, mental health problems as well as those with behaviours that challenge

— The Care Bill has a crucial role in ensuring that the health and care system addresses recent, high-profile failings. As part of the focus on protecting the most vulnerable in society from poor quality care, it is vital that the Bill gives greater priority to supporting people with learning disabilities and challenging behaviours

— To achieve this aim, Craegmoor has identified the following areas where, in our view, the current proposals can be strengthened to better support those people with complex needs to lead safe and independent lives:

— Prioritisation: Ensure local commissioners are focused on driving the same standards of high quality care for learning disabilities services as those being advocated to NHS services

— Quality and transparency: Promote more effective monitoring and quality reporting for learning disability services, similar to that being adopted across NHS services

— Regulation: Ensure the levels of regulatory scrutiny are applied consistently across all learning disability care providers throughout the market

— Fragmentation: Greater clarity on how the Bill will support people with learning disabilities to access the wide range of interventions required to meet their complex and evolving care needs

Craegmoor welcome the opportunity to submit written evidence to the Public Bill Committee considering the Care Bill to ensure that the legislation fully caters for the needs of all those adults requiring access to high quality care and support services, including those with learning disabilities.

This document sets out our views on how the Bill can support the protection of the most vulnerable people using health and social care services. It also includes an overview of the processes in place at Craegmoor, and throughout the Priory Group, to support the delivery of high quality services and provide greater openness about the standards of care we are providing.

Ensuring the Care Bill delivers for adults with learning disabilities

Craegmoor fully supports the aim of the Care Bill to bring together existing care and support legislation into a single framework to establish an adult social care system geared towards people’s wellbeing and reforms the funding system for care and support. This includes important reforms for regulating healthcare providers in response to the recommendations of the Francis Inquiry following the failings at Mid-Staffordshire Foundation Trust.

However, it is important that those provisions primarily geared towards secondary care services are balanced with robust measures aimed at protecting vulnerable adults in residential and educational care settings. These must also underpin the commissioning of the full range of services and support which will enable those with life-long care needs to lead safe and independent lives.

This legislation has a vital role in tackling the different aspects and underlying causes of poor quality adult care and support services such as poor organisational leadership, staff training and audit processes, highlighted as key findings in the Serious Case Review of Winterbourne View.

Recommendation: The Bill must support the implementation of the key tenets of the Transforming Care programme which aims to transform services for people with complex and challenging needs and behaviours.
Oversight and regulation

Craegmoor welcomes moves to give the Care Quality Commission (CQC) greater operational independence, as well as establishing a more specialist approach to inspections. We believe that a more tailored regulatory processes should provide more insightful information on the quality of care delivered by providers and make it easier for commissioners to benchmark services.

In order for the new regulatory regime to operate effectively there needs to be steps taken to define what constitutes high quality care, including what effective safeguarding looks like. The new regulatory framework must evidence-based and proportionate in the way it is applied to providers. It will be important the public, independent and voluntary sectors are monitored and inspected to the same level to maintain consistency across the market.

In its current form, the Care Bill includes the creation of a new legal framework designed to ensure that key organisations and individuals with responsibilities for adult safeguarding can agree on how they must work together and what roles they must play to keep adults at risk safe.

Practically, the Bill requires local authorities to set up a Safeguarding Adults Board (SAB) in their area, giving these bodies a clear basis in law for the first time. At present, SABs must include representation from the local authority, the NHS and the police, develop shared plans for safeguarding and report to the public annually on their progress.

Recommendation: The Bill should look to strengthen the contribution and insights local providers can offer in supporting SABs to discharge their statutory functions. Clear and effective dialogue between commissioners and providers, as well as regulatory and other agencies, is key to helping to mitigate the risk of abuse or neglect of service users.

Focus on high quality care and transparency

Craegmoor is focused on operating market-leading practices, through care quality processes and governance arrangements, and looking at new ways of delivering services more effectively.

We aim to improve on best practice standards by listening to our service users and being open and transparent about the performance of our services. By putting our users first and by understanding people better, we can offer tailored care and support packages and improve what we do. As part of this commitment, we have developed the first annual Quality Account for Craegmoor services. The findings from the Craegmoor Quality Account for 2012–13 are shown below.

LEARNING DISABILITY SERVICES:
— 98% of service users have a current assessment of their needs
— 98% of service users have a named key worker

AUTISM SERVICES:
— 100% of service users have a named key worker
— 94% of service users are engaged in activities in the local community

MENTAL HEALTH SERVICES:
— 98% of support plans include personalised, outcome driven goals
— 90% of service users have a named key worker

Improving monitoring and quality reporting in the adult care and support sector should be an important mechanism for driving better standards of care.

Recommendation: The Bill should give consideration to expanding the use of Quality Accounts by public, independent and voluntary care providers. This would give greater disclosure to patients, commissioners and regulators about the quality of the care delivered by individual providers, enable easier benchmarking of services and make informed decisions about accessing, procuring and scrutinising services.

Service integration

For vulnerable individuals with complex and evolving care and support needs, timely referral to appropriate services is vital to ensure that they receive an appropriate package of care in a timely way. Integrated care and support needs to be continuous and coordinated with services tailored to the needs and preferences of the individual, their carer and family. This approach means moving away from episodic care to a more holistic view of health, care and support needs which involves primary care, community health, social care, the acute sector and wider partners.

Crucially, the Care Bill gives local councils a duty to promote integrated services which provides them with the opportunity to develop more localised solutions which enable more joined-up care. Providers can offer
important operational experience and detailed understanding of user and patient needs to assist commissioners in the designing and development of new or existing services.

Craegmoor works in partnership with our service users and their families, as well as commissioners, regulators and other stakeholders, to provide the best possible outcomes at every stage of an individual’s care pathway. From our experience, the willingness of NHS and local authority commissioners to engage with providers of frontline services has been mixed, and the Bill presents an opportunity to develop this further.

Recommendation: The Bill should ensure that health and wellbeing boards, in discharging their statutory functions for integrating care in local areas, are actively engaging with care providers to ensure that services are meeting the needs of local patients.

Case studies

By providing a seamless transition for our service users as they progress between higher and lower dependency services, we ensure continuity of care that underpins the delivery of successful outcomes.

Our integrated approach to treatment supports service users’ progression by providing sustainable placements and, where appropriate, the opportunity to move back into a community setting. This means that service users within Craegmoor can benefit from rapid access to acute and complex mental healthcare services within Priory Healthcare, as well as specialist educational facilities within our education services. Our older service users can also receive specialist care to meet their changing needs within our Amore Care division.

We have included below a series of case studies to give an overview of how the different types of personal services we deliver are helping those accessing our services to achieve positive outcomes:

Case study A:
— Neil has been in services for the last 20 years and has made the transition through our integrated care pathway—through secure services, nursing care, rehabilitation and now supported living
— He started with a high package with visits most days, but for the last two years he decided that he wanted an on-call package that was tailored to suit his support needs better. Neil now has a 24/7 on-call package, with 6 hours per week face-to-face support built in if he chooses to use them
— Neil has become more independent and adapted well to community life. He is now the volunteer leader for local projects, working along side the council teams and community leaders on local projects

Case study B:
— Shay has made the transition through from nursing/rehabilitation into supported living
— He has a tailored support plan that is built around the support needs that he identified himself in relation to managing his finances and budgeting.
— Since his admission in January 2013, he has already had one reduction in support hours
— Over the last two months, Shay has progressed from collecting his monies from the registered office twice a week, to opening his own bank account and having an amount transferred to him each week

Case study C:
— Nicolas has lived in Craegmoor accommodation for almost a decade after 60 years living in different residential settings, including long-stay institutions
— In March 2010, we supported Nicolas to move out of central accommodation and into his own nearby flat, including help from his designated care manager to secure a mortgage from a specialist provider
— He continues to receive regular support throughout the day with daily tasks and remains in close contact with many of the friends he made when he was living in central accommodation

About Craegmoor

Craegmoor, part of the Priory Group of Companies, is the country’s leading independent provider of support for people with learning disabilities, autism, complex needs, mental health problems as well as those with behaviours that challenge. The breadth and depth of our range of services means that we are able to provide flexible, evidence-based care, which is personalised to meet the needs and preferences of the individual.

January 2014

Written evidence submitted by Social Care Institute for Excellence (SCIE) (CB 33)

About SCIE

The Social Care Institute for Excellence (SCIE) improves the lives of people who use care services by sharing knowledge about what works. We are an independent charity working with adults, families and children’s social
care and social work services across the UK. We also work closely with related services such as health care and housing.

We gather and analyse knowledge about what works and translate that knowledge into practical resources, learning materials and services including training and consultancy. Our work helps to improve the knowledge and skills of those working in care services. This includes managers, frontline staff, commissioners and trainers. People who use these services and their families also use our resources to make informed decisions about their care.

**SUMMARY**

SCIE supports the Care Bill and its aim to establish a coherent and comprehensive piece of legislation that has the wellbeing of individuals at its heart.

We note the importance of ongoing implementation support for organisations and individuals across the sector and in allied sectors such as health and housing. This support should consist of a coordinated effort from the centre to ensure key bodies are clear about their duties under the new legislation and implementation is based on existing best practice.

**COMMISSIONING AND PREVENTION**

The Bill says little about the role of commissioning. Good commissioning practice such as strategic investment in micro-providers, user-led services and other innovative schemes is central to supporting the preventative agenda. Commissioners can also support transition for younger adults by working closely with providers across the children’s and adults service boundaries.

SCIE would welcome further clarity on the role of local authorities and NHS bodies as commissioners and ‘place shapers’; developing and investing in community capacity and supporting the effectiveness and availability of care provision in the local area in collaboration with people that use services, their carers, families and communities.

**INTEGRATION**

The provisions of the Bill alone will not overcome the organisational or cultural barriers to effective integrated working. Although the introduction of the ‘Better Care Fund’ is welcomed, it should not be seen as addressing the difficulties associated with joint working across health, social care and allied sectors.

This will rely upon local organisations working collaboratively within an agreed framework. The Research Briefing published by SCIE in 2012 on the factors that help or hinder integrated working highlighted that this requires:

- A shared vision and objectives
- Clear roles and responsibilities
- Excellent communication and effective information sharing
- Supportive leadership
- Establishing a culture of trust and respect.

These factors should form the basis of government support for implementing bodies in the shape of regulations or guidance.

**PARTICIPATION AND CO-PRODUCTION**

The definition of co-production is still fluid, but it is the term that is gaining common currency as the default description of user, carer and citizen involvement in public services. The Co-production Critical Friends Group, a cross sector network (which SCIE is a member of) has developed the following definition:

“Co-production is a relationship where professionals and citizens share power to plan and deliver support together, recognising that both have vital contributions to make in order to improve quality of life for people and communities.”

SCIE welcome the focus of the Bill on the individual’s involvement in processes relating to them. However, we would welcome the inclusion of a duty to co-produce the commissioning cycle—the broader planning, implementation and evaluation of local authority and NHS interventions.

Commissioners and providers should be much more proactive in systematically building co-production in a variety of forms into service development, delivery and improvement, management and staff training and quality improvement systems. It is vital that users of services are empowered to have more strategic control over the services they use, including through user-led organisations if we are to see the development of a more responsive and personalised system of care and support.

*February 2014*
1. This is evidence about certain aspects of the Care Bill and particular Part 2 Clause 80 Duty of Candour and Clause 90 Offence and 91 Penalties.

2. From October 2008 until February 2013 I was a member of Julie Bailey’s campaign group Care the NHS. Along with the other members of the group I was, therefore, a determined campaigner for the Public Inquiry which reported a year ago and for a radical improvement in the levels of patient safety afforded to NHS patients.

3. The Public Inquiry laid bare the lack of an appropriate regulatory system for the NHS. Healthcare worldwide is probably the only safety-critical sector lacking in appropriate regulatory structures; sadly the NHS is no exception.

4. The NHS and the UK care and healthcare sectors have many regulators but they each cover small parts of the whole. Robert Francis demonstrated how unsatisfactory this is; other safety-critical sectors tend to have a single regulator covering all aspects of the licensing of personnel and provider organisations.

5. UK civil aviation is regulated in an all-encompassing legislative structure which enables one body, “Civil Aviation Authority UK”, to cover all elements of ensuring safety for UK air passengers.

6. One CAA UK “directorate” covers all elements of personnel, airline, and aircraft manufacturer regulation and licensing.

7. An entirely separate investigatory body, “The Aircraft Accident Investigation Branch,” reports to the Transport Secretary, and carries out all investigations of accidents and incidents.

8. The UK rail, maritime, nuclear, and offshore drilling sectors have similar structures regulating the safety of their operations.

9. The key suggestions set out in this document were conceived by me as a member of Cure the NHS after the publication of the Healthcare Commission’s report into Mid Staffs in March 2009. I drew on my own twenty years of experience working for a number of major airlines in ground operations roles, including in safety training roles, and believe strongly that a “single regulator” structure is essential for proper regulation, inspection and audit.

10. The suggestions were sent to Richmond House in a document called “Turning the NHS the Right Way Up” in Summer 2009 and then incorporated in extended form in the group’s submission to Steve Field’s “Future Forum” in October 2010. In December 2010 I set out a detailed account of the ideas in my written and oral evidence to the Public Inquiry. In December 2011 I incorporated the key suggestions as “A Blueprint for a New NHS” in the appendix to the group’s closing submission to the Public Inquiry. Viz:-

10A. IMPLEMENTING TWO ESSENTIAL SYSTEMS

Develops an NHS “patient safety management system” which will set out the underlying patient safety principles and activities to enable zero harm to be delivered.

Charges each provider with developing a complementary “Patient Safety Management System” to turn the NHS system into a way of working for its own particular circumstances.

Develops NHS “Patient Care Quality Management System” to provide one authoritative source for all standards, procedures, policies, processes, protocols, and policies used in treating patients.

Charges each provider with developing a complementary “Patient Care Quality Management System” to turn the NHS system into a way of working for its own particular circumstances.

10B. ESTABLISHING A SINGLE REGULATORY BODY

Establishes a “virtual single regulator” by immediately instigating a daily safety and quality review of NHS operations at chief executive level, instigated by the Care Quality Commission, with the participation of the chief executives of all of the current “regulatory” bodies.

Moves as quickly as possible, acknowledging the many organisational changes required, to turn the “virtual single regulator” into a “real single regulator”; drawing under one umbrella all of the current bodies which carry out this task but in a way that is far too disjointed.

Safety and quality cannot be inspected or regulated into the NHS; it is the primary responsibility of frontline carers to deliver only safe, high quality care, and in effect to “regulate” themselves and their colleagues.

10C. “STOP AND MAKE SAFE”—ASSURING PATIENTS AND COMMUNITIES

Commands every provider to deliver regular “stop and make safe” sessions to its community, comprising standardised mortality ratios, anonymised serious incident reports, summarised and anonymised serious complaints, and other key safety and quality information.
10d. Drawing Coroners into the Assurance of Patient Safety and Quality of Care

Ensures that all medical examiners are appointed.

Ensures that inquests are held in all appropriate cases and that the verdicts become patient safety information at local and national level.

10e. Investigation of Healthcare Failures

Establishes a small team of healthcare investigators to move in when evidence of failure comes to light. This team would report directly to the Minister of State.

11. Other recommendations covered the transformations of culture essential to meet Cure the NHS’s goal that no other patient should ever again have to endure the appalling treatment and care which the patients of Mid Staffs Hospital endured.

12. Sadly these system and regulatory aspects of patient safety did not feature in the report of the public inquiry as an entity in spite of my presenting them in my own written and oral evidence and in spite of their featuring significantly in the closing submission of Cure the NHS. Robert Francis did of course addresses them widely in his 290 recommendations but I believe they should have been gathered together as elements of an identifiable system to be imposed wholesale on the NHS and other providers of both health care and social care. This should have been the framework for an entirely new legislative framework for patient safety.

13. I have now published in the iPad app Zero Harm Healthcare name available from the Apple “App Store” how the systems can be implemented at hospital level.

14. However the essence of Cure the NHS’s submission “Zero Harm, Right First Time”, or at least the “Zero Harm” part, did feature in the Prime Minister’s presentation of Robert Francis’s report of the Public Inquiry in the House of Commons on 6 February 2013 in the House of Commons –

“...Quality of care means not accepting that bed sores and hospital infections are somehow occupational hazards—that a little bit of these things is somehow okay.

It is not okay; they are unacceptable—full stop, end of story. That is what Zero Harm means.

I have therefore asked Don Berwick, who has advised President Obama on this issue, to make zero harm a reality in our NHS.”

15. So I believe that given the epoch-making impact which the Mid Staffs Hospital disaster has had on the NHS and the wider healthcare world that there should be a comprehensive Bill to consolidate and cover all aspects of “patient safety and quality of treatment and care”. This vital subject which is as yet too-little discussed in any quarter but which lies at the heart of delivering the age-old maxim “do no harm” deserves its own Bill which is not only legislation but which forms the authoritative source for patients and public to read how the law is framed to keep their loved ones and themselves safe and how health providers will be held accountable for their actions.

16. As a member of Cure the NHS I developed a substantial part of a layperson’s draft of such a Bill.

17. Until such a comprehensive piece of legislation is brought forward Part 2 Clause 80 Duty of Candour does seem a little bit of an orphan and a little brief. My belief is that a duty of candour anyway exists in the codes of conduct of doctors and nurses. Rather than have a general Duty of Candour as envisaged here I believe any duty additional to what already exists in the codes of conduct should be built into a “mandatory incident reporting system”.

18. Indeed only recently NHS England have announced a strengthening of the system for patient safety alerts and it is as part of this system and the rapid generation of incident reports which are themselves the first element in the alerts loop that such a duty belongs.

19. That incident—alert system itself belongs within the Patient Safety Management System which I advocate above.

20. A mature an highly-successful system of this nature has been managed by UK CAA from many years and is well-worth some study.

21. I do not understand if Part 2 Clause 90 Offence and clause 91 Penalties are meant to apply to Clause 80 Duty of Candour admissions. If they are I urge the members of the Bill Committee to weigh very carefully to what extent investigations and legal processes should further to be brought into the healthcare environment beyond those which are already there and at the disposal of the Police and the Health and Safety Executive.

22. I am in no doubt that the disaster at Mid Staffs Hospital was first and foremost a failure of professional discipline and commitment which spread widely across the hospital staff. One could cite very many examples of similar failures. The Patient Safety Management System I advocate would provide the legislative structure
to help prevent such failures, the cultural transformation set out in Blueprint for a New NHS would provide the
behavioural change.

February 2014

Written evidence submitted by Buckinghamshire County Council (CB 35)

Summary of Buckinghamshire County Council’s Written Evidence

This submission will focus exclusively on Mental Health after-care services which are dealt with under clause 74 of the Care Bill.

Mental Health after-care services are provided under section 117 of the Mental Health Act 1983 to meet a
need arising from or relating to the mental disorder of the person concerned.

The Care Bill does not provide clarity around what a “joint” responsibility between health and social
care means in respect of section 117 funding arrangements. Section 117 of the Mental Health Act 1983
imposes an enforceable joint duty on health and social services authorities to provide after-care services for
certain categories of mentally disordered patients who have ceased to be detained and leave hospital. There
are many different interpretations across the country of what a joint responsibility between health and social
care means, resulting in very different funding impacts for CCGs (Clinical Commissioning Groups) and Local
Authorities. The Care Bill could and should be used as an opportunity to address this issue once and for all to
provide clarity, consistency and to avoid disputes.

House of Commons Public Bill Committee: Care Bill

Buckinghamshire’s Written Evidence

1. This submission will focus on Clause 74 of the Care Bill

The Care Bill does not provide clarity around what a ‘joint’ responsibility between health and social
care means in respect of Section 117 funding arrangements

2. Section 117 of the Mental Health Act 1983 imposes an enforceable joint duty on health and social services
authorities to provide after-care services for certain categories of mentally disordered patients who have ceased
to be detained and leave hospital. This is a stand-alone duty and is not a gateway provision which places
a duty on the responsible after-care bodies to provide services under other legislation such as the National
Assistance Act 1948 or the National Health Service 2006. A consequence of this is that the normal rules about
commissioning responsibility (in the NHS) or ordinary residence (for social services) do not apply.

3. Social services and health bodies should establish jointly agreed policies on providing services under
section 117 (see HSC 000/003:LAC(2000)3). Also functions under section 117 are prescribed NHS functions
which may be the subject of partnership arrangements with local authorities under section 75 of the National
Health Service Act 2006.

The current lack of clarity about joint responsibility has led to many different “interpretations” with
consequent funding impacts on CCGs and Local Authorities.

4. There are many different interpretations of joint responsibility in respect of section 117 funding
arrangements across the country that result in very different funding impacts for CCGs and Local Authorities.
Buckinghamshire has carried out a review of what is taking place in other areas which includes the following
funding arrangement possibilities for eligible s.117 clients:-

1. Free Nursing Care entitlement is the extent of CCG funding and the Local Authority picks up the rest
2. Local agreement to share the costs on a 50/50 basis which reflects the joint nature of the legal duty.
3. Use of the Decision Support tool and Continuing Care Domains to indicate the responsible body
for s.117 after-care. So where a client meets the threshold for health funding, then the CCG is the
responsible funding body for s.117 after-care. In all other cases the Local Authority is the responsible
funding body.
4. Use of financial thresholds. So anything over x is funded by Health and anything below is social care
and other versions of this.
5. Funding arrangements based on the individual lines in a care plan and an assessment around whether
they are health or social care needs.

There are significant financial impacts and financial risks for both health and social care as a result of
different interpretations of section 117 leading to a range of funding arrangements.

5. The table below effectively demonstrates the impact of these differential payments we have taken a
illustrative but representative figure of £9,000,000 spend on Mental Health After Care. The figures illustrate
that if a joint 50/50 split between partner organisations is not adopted on an indicative spend of £9,000,000 at
the top end of the inequity of split (80/20) one partner organisation is providing £2.7 million of funding over and above that of a joint split and contributing £5.4 million more that its “partner”.

Section 117 Differential funding contributions and their impact on the contributions of partner organisations working “jointly”.

<table>
<thead>
<tr>
<th>Range of % splits</th>
<th>eg LA</th>
<th>eg CCG</th>
<th>Total Spend on Mental Health After Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>50/50</td>
<td>£4,500,000</td>
<td>£4,500,000</td>
<td></td>
</tr>
<tr>
<td>60/40</td>
<td>£5,400,000</td>
<td>£3,600,000</td>
<td>£9,000,000</td>
</tr>
<tr>
<td>70/30</td>
<td>£6,300,000</td>
<td>£2,700,000</td>
<td></td>
</tr>
<tr>
<td>80/20</td>
<td>£7,200,000</td>
<td>£1,800,000</td>
<td></td>
</tr>
</tbody>
</table>

The lack of clarity about ‘joint’ responsibility between health and social care in respect of Section 117 funding arrangements can lead to disputes arising between partner agencies.

6. Health Service Circular HSC 2000/003 and Local Authority Circular LAC 2000(3) states that:

‘Social services and health authorities should establish jointly agreed local policies on providing Section 117 Mental Health Act after-care. Policies should set out clearly the criteria for deciding which services fall under Section 117 Mental Health Act and which authorities should finance them. The Section 117 Mental Health Act Aftercare plan should indicate which service is provided as part of the plan. After-care provision under Section 117 Mental Health Act does not have to continue indefinitely. It is for the responsible health and social services authorities to decide in each case when after-care provided under Section 117 Mental Health Act should end, taking account of the patient’s needs at the time. It is for the authority responsible for providing particular services to take the lead in deciding when those services are no longer required. The patient, his/her carers, and other agencies should always be consulted’

7. There are a number of local authorities which, are in dispute with their local area CCG (and before this PCT) around responsibility for the provision of after-care services as a result of the lack of clarity around what ‘joint’ means in terms of funding arrangements for s117 after-care packages between the CCG’s and the Local Authority.

8. Where disputes cannot be resolved between the “joint” partnership the local authority may have to resort to a court judgement with the associated legal costs which the Local Authority and its ratepayers will have to fund, an additional cost to establish clarity and equity of funding with no benefit to either rate payers or service users.

9. A whole systems approach to providing care and support and ensuring people’s health and well-being and preventing them from losing their independence requires a number of elements. These include an understanding of the needs and assets of the local population, agreed shared priorities and that the partners take a rounded, whole system view of value for money, in which investment and benefit is transparent and fairly balanced between partners. The current lack of defined joint approach to funding mental health aftercare makes a whole systems approach and integrated working between Health and Social Care much more problematic.

Impact on Service Users

10. If joint responsibility does not mean a joint approach to funding this can produce significant and direct inequity for residents and more specifically services users. In our example an 80/20 spread would result in the local authority partner spending an additional £5.7 million from its limited envelope of financial resources. This impacts directly on budgets and would lead to a reduction of service spending either in adult social care and/or the local authority as a whole.

Parliamentary Scrutiny of the Care Bill

11. On Thursday 23rd January the Public Bill Committee were scrutinising clause 74 of the Care Bill and specifically considering the definition of aftercare. During the debate the minister of state for the department of health cited another member of the committee who had said that “legislation can sometimes provide clarity, as long as the words used are clear” he also stressed the importance of using targeted definitions. We feel that “jointly” and its relationship with funding is too important an area to remain unclear and ill defined.

Conclusion

12. There is an opportunity with the passage of the care bill through parliament to seek an amendment to the Bill to clarify the position in law. We believe that the Care Bill provides the best possible opportunity to address this issue once and for all and provide the clarity around what we consider to be an opaque piece of legislation, namely Section 117 of the Mental Health Act 1983. If the Care Bill can be amended to clarify the position in law this would provide a clear determination of what “joint” means in terms of funding arrangements for Mental Health after care services. The impact would be to provide clarity, consistency and avoid disputes. A
key consideration would be to ensure that the service user is at the heart of everything we do and to avoid any actions and activities with a negative impact for service users and our residents.

BUCKINGHAMSHIRE COUNTY COUNCIL

10. Buckinghamshire County Council is a local authority whose responsibilities include Adults and Family Wellbeing. Buckinghamshire’s population is approximately 505,300 people (census 2011)

   — 84,000 people (16.7%) of the population is currently aged over 65. By 2025 this number will increase by 36% people are aged 65+
   — 11,000 people (2.2%) of the Buckinghamshire population is currently aged 85+. This number is expected to increase by 84% by 2025.
   — During 2012/13 we supported 128,590 people to live in their own homes.
   — During 2012/13 we supported 2,298 people living in residential or nursing homes
   — Approximately 1 in 12 (42,108) people in the population have some form of Mental Illness.

11. We have a strong focus on Preventative work, our Prevention Matters programme focuses on people who are on the cusp of needing social care or who are at risk of needing more intense health or social care and support. During 2012/13 we are investing £4.14 million in Prevention Matters.

12. Our Day opportunities programme has meant that a significant proportion of our day service users are able to spend their days using services provided in the communities rather than staying in a day centre. This has enabled people to access a wide range of activities.

13. We have recently successfully set established a Local Authority Trading Company that operates independently from, but is completely owned by the council. This means that people can buy council run services with Direct Payments if they choose having greater control on the services they purchase and how they are delivered.

14. We fully recognise, and value the important role that our many partners across the districts, other statutory and voluntary and community members have in ensuring the success of our Health and Wellbeing priorities. By working together with Health partners we can share resources effectively and influence decisions to make sure our residents and vulnerable adults receive the best care possible and in a joined up way.

Source documents

Health Service Circular HSC 2000/003
Local Authority Circular LAC 2000(3)
February 2014

Written evidence submitted by FirstStop (CB 36)

DILNOT EFFECT ON AVERAGE PERSON LIVING AS A SELF-FUNDER IN A CARE HOME UNTIL REACHING £72,000 CAP—CARE BILL PART 1 CLAUSE 15

About EAC FirstStop Advice

EAC FirstStop Advice for Older People is a free information and advice service designed to help older people decide how best to meet their needs for support, care housing and accommodation. EAC FirstStop advice is provided nationally and locally by telephone, Email and web services, and face to face locally through 25 partner agencies. EAC FirstStop is most likely the leading advice service for older people and their families and carers in the UK, integrating housing, care money, legal issues and rights advice across the whole spectrum of care and accommodation from adapting your own home through to end of life nursing home care. It is led by the charity Elderly Accommodation Counsel (EAC) and mainly funded by the Department for Communities and Local Government since 2009, which is also supporting its expansion of local face to face services during 2013–15.

Care Bill Part 1 Clause 15

Using figures from the Dilnot report and applying Government inflation rate to 2016/17

<table>
<thead>
<tr>
<th></th>
<th>Dilnot Report 2012/current</th>
<th>Inflated to 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Property and Savings Wealth</td>
<td>124,000</td>
<td>146,320</td>
</tr>
<tr>
<td>Median Net Income</td>
<td>11,284</td>
<td>13,315</td>
</tr>
<tr>
<td>Attendance Allowance (AA)</td>
<td>3,827</td>
<td>4,516</td>
</tr>
</tbody>
</table>
Using the above figures ignoring any further annual inflation and applying the revised means test results in the following:

**Scenario 1: Applying Dilnot when capital diminishes to £118,000**

<table>
<thead>
<tr>
<th>Year</th>
<th>Care</th>
<th>Living Costs</th>
<th>Income less PX</th>
<th>AA £87 per week</th>
<th>From Capital Tariff £1/250</th>
<th>From Capital</th>
<th>LA Payment</th>
<th>Residue Capital from £146,320</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>21,748</td>
<td>12,000</td>
<td>(11,929)</td>
<td>(4,524)</td>
<td>(17,295)</td>
<td>129,025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 (8 months Self funding)</td>
<td>14,499</td>
<td>8,000</td>
<td>(7,953)</td>
<td>(3,016)</td>
<td>(11,530)</td>
<td>117,495</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 (4 months LA Funding)</td>
<td>7,249</td>
<td>4,000</td>
<td>(3,976)</td>
<td>(348)</td>
<td>(7002)</td>
<td>271</td>
<td>110,493</td>
<td></td>
</tr>
<tr>
<td>Year 3 LA Funding</td>
<td>21,748</td>
<td>12,000</td>
<td>11,929</td>
<td>Nil</td>
<td>(19,446)</td>
<td>2,373</td>
<td>91,047</td>
<td></td>
</tr>
<tr>
<td>Year 4 to CAP (3.73 months)</td>
<td>6,756</td>
<td>3,727</td>
<td>3,707</td>
<td>Nil</td>
<td>(4,788)</td>
<td>1,988</td>
<td>86,259</td>
<td></td>
</tr>
</tbody>
</table>

**Total Cost to Local Authority £4,632**

**Total Cost to Individual from Capital £60,061**

On accepting local authority support attendance allowance is lost after 4 weeks of LA funding. This raises the question: When is it worth seeking local authority support?

**Scenario 2: Not Applying Dilnot and keeping Attendance Allowance**

<table>
<thead>
<tr>
<th>Year</th>
<th>Care</th>
<th>Living Costs</th>
<th>Income less PX</th>
<th>AA £87 per week</th>
<th>From Capital Tariff £1/250</th>
<th>From Capital</th>
<th>LA Payment</th>
<th>Residue Capital from £146,320</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>21,748</td>
<td>12,000</td>
<td>(11,929)</td>
<td>(4,524)</td>
<td>(17,295)</td>
<td>129,025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>21,748</td>
<td>12,000</td>
<td>(11,929)</td>
<td>(4,524)</td>
<td>(17,295)</td>
<td>111,730</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>21,748</td>
<td>12,000</td>
<td>(11,929)</td>
<td>(4,524)</td>
<td>(17,295)</td>
<td>94,435</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 to CAP</td>
<td>6,756</td>
<td>3,727</td>
<td>(3,707)</td>
<td>(1,406)</td>
<td>(5,370)</td>
<td>89,065</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Cost to Local Authority £ Nil**

**Total Cost to Individual from Capital £57,255**

**Saving £2,806**

The point at which it ceases to be beneficial to claim Attendance Allowance and accept LA support is when the capital tariff applied by the local authority on £118,000 would diminish by the equivalent of AA (21,750/250 x £1 = £87) thus £96,250
Scenario 3: Point at which to cease AA and Apply for LA Funding

<table>
<thead>
<tr>
<th>Year</th>
<th>Care Living Costs</th>
<th>Income less PX</th>
<th>AA £87 per week</th>
<th>From Capital Tariff £1/250</th>
<th>From Capital</th>
<th>LA Payment</th>
<th>Residue Capital from £146,320</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>21,748</td>
<td>12,000</td>
<td>(11,929)</td>
<td>(4,524)</td>
<td>(17,295)</td>
<td></td>
<td>129,025</td>
</tr>
<tr>
<td>Year 2</td>
<td>21,748</td>
<td>12,000</td>
<td>(11,929)</td>
<td>(4,524)</td>
<td>(17,295)</td>
<td></td>
<td>111,730</td>
</tr>
<tr>
<td>Year 3 Self Funding 46 wks</td>
<td>19,238</td>
<td>10,615</td>
<td>(10,552)</td>
<td>(4002)</td>
<td>(15,299)</td>
<td></td>
<td>96,431</td>
</tr>
<tr>
<td>Year 3 LA Funding 6 wks</td>
<td></td>
<td></td>
<td></td>
<td>(348)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 to CAP 3.73 months</td>
<td>6,756</td>
<td>3,727</td>
<td>(3,707)</td>
<td>5,053</td>
<td>1,723</td>
<td></td>
<td>90,107</td>
</tr>
</tbody>
</table>

Total Cost to Local Authority £2,624
Total Cost to Individual from Capital £56,213
Saving £3,848

It therefore seems iniquitous that self-funding residents can be inadvertently out of pocket because of the way DWP benefits and LA Charging work together. To overcome this a change in DWP regulations would be required to enable individuals to retain their Attendance Allowance when LA funding commences.

There would be a cost involved for the DWP to allow Attendance Allowance to be retained, see scenarios 2 and 3 below, but these costs would be incurred anyway if the individual were to understand Dilnot and take the advised route 2 or 3. Counteracting this there would however be a cost saving to the LA because AA would count as income and contribute towards the cost.

Scenario 4: Applying Dilnot when eligibility met after 1.5 years

According to BUPA Care Homes who accommodate both state funded and self funding care home residents the average life expectancy in their care homes is 2.5 years for state funded residents and 4 years for self funding residents. The reason for this is because Self-funding people enter care earlier than local authority funded residents based on need. Dilnot recommends “a minimum eligibility threshold to be set nationally at ‘substantial’”, therefore if BUPA’s figures are correct, self-funding residents may have to wait 1.5 years before meeting the need threshold. Taking 4.8 years to reach the £72,000 Cap.

<table>
<thead>
<tr>
<th>Year</th>
<th>Care Living Costs</th>
<th>Income less PX</th>
<th>AA £87 per week</th>
<th>From Capital Tariff £1/250</th>
<th>From Capital</th>
<th>LA Payment</th>
<th>Residue Capital from £146,320</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>21,748</td>
<td>12,000</td>
<td>(11,929)</td>
<td>(4,524)</td>
<td>(17,295)</td>
<td></td>
<td>129,025</td>
</tr>
<tr>
<td>Year 2 (6 months Self funding)</td>
<td>10,874</td>
<td>6,000</td>
<td>(5,964)</td>
<td>(2,262)</td>
<td>(8,648)</td>
<td></td>
<td>120,377</td>
</tr>
<tr>
<td>Year 2 Cap Start (7 weeks Self Funding)</td>
<td>2,927</td>
<td>1,615</td>
<td>(1,605)</td>
<td>(609)</td>
<td>(2,328)</td>
<td></td>
<td>118,049</td>
</tr>
<tr>
<td>Year 2 (19 weeks LA funding)</td>
<td>7,947</td>
<td>4,385</td>
<td>(4,359)</td>
<td>(348)</td>
<td>(7,625)</td>
<td>Nil</td>
<td>110,424</td>
</tr>
<tr>
<td>Year 3 (LA funding)</td>
<td>21,748</td>
<td>12,000</td>
<td>(11,929)</td>
<td>Nil</td>
<td>(19,432)</td>
<td>2,387</td>
<td>90,992</td>
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<tr>
<td>Year 4 (LA funding)</td>
<td>21,748</td>
<td>12,000</td>
<td>(11,929)</td>
<td>Nil</td>
<td>(15,390)</td>
<td>6,429</td>
<td>75,602</td>
</tr>
<tr>
<td>Year 5 to CAP 42 wks)</td>
<td>17,630</td>
<td>9,692</td>
<td>9,635</td>
<td>Nil</td>
<td>(9,845)</td>
<td>7,842</td>
<td>65,757</td>
</tr>
</tbody>
</table>

Total Cost to Local Authority 16,658
Total Cost to Individual from Capital £80,563
There is a concern that once you reach your cap the local authority would only assist with your care costs up to the amount they would usually pay (their usual rate) for someone with your assessed needs. If the care chosen exceeds that cost you will be required to find a third-party to top-up the cost. Present law does not permit individuals to fund their own top-ups. However, if the aforementioned top-up law was changed to permit individuals to use their capital below the means test threshold then there is greater depletion of capital.

Scenario 5: Applying Dilnot with required £100 pw Top Up

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Living Costs plus Top-up</th>
<th>Income less PX</th>
<th>AA £87 per week</th>
<th>From Capital Tariff £1/250</th>
<th>From Capital/Top up</th>
<th>LA Payment</th>
<th>Residue Capital from £146,320</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21,748</td>
<td>17,200</td>
<td>(11,929)</td>
<td>(4,524)</td>
<td>(22,495)</td>
<td></td>
<td>123,825</td>
</tr>
<tr>
<td>Year 2 (13 wks Self funding)</td>
<td>5,437</td>
<td>4,300</td>
<td>(2,982)</td>
<td>(1,131)</td>
<td>(5,624)</td>
<td></td>
<td>118,201</td>
</tr>
<tr>
<td>Year 2 (39 wks LA Funding)</td>
<td>16,311</td>
<td>12,900</td>
<td>(8,946)</td>
<td>(348) 4 weeks</td>
<td>(15,756)</td>
<td>(3,900)</td>
<td>261</td>
</tr>
<tr>
<td>Year 3 LA Funding</td>
<td>21,748</td>
<td>17,200</td>
<td>(11,929)</td>
<td>Nil</td>
<td>(16,961)</td>
<td>(5,200)</td>
<td>4,858</td>
</tr>
<tr>
<td>Year 4 to CAP</td>
<td>6,756</td>
<td>5,343</td>
<td>(3,707)</td>
<td>Nil</td>
<td>(3,800)</td>
<td>(1,616)</td>
<td>2,976</td>
</tr>
<tr>
<td>Year 4 onwards post cap top-up per annum from capital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(5,200)</td>
</tr>
</tbody>
</table>

Total Cost to Local Authority £8,095

Total Cost to Individual from Capital £75,352 to cap plus a further £5200 per annum thereafter

Summary

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Cost To LA</th>
<th>Additional AA Cost to DWP</th>
<th>Cost to Citizen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 1- Applying Dilnot on reaching £118,000 threshold</td>
<td>£4,632</td>
<td>Nil</td>
<td>£60,061</td>
</tr>
<tr>
<td>Scenario 2—Not applying Dilnot until reaching Cap</td>
<td>Nil</td>
<td>7,090</td>
<td>£57,255</td>
</tr>
<tr>
<td>Scenario 3—Dilnot timed entry</td>
<td>£2,624</td>
<td>5,510</td>
<td>£56,213</td>
</tr>
<tr>
<td>Scenario 4- Delayed eligibility criteria</td>
<td>£16,658</td>
<td>Nil</td>
<td>£80,563</td>
</tr>
<tr>
<td>Scenario 5—With top-up from capital</td>
<td>£8,095</td>
<td>Nil</td>
<td>£75,352 plus £5,200 pa post Cap</td>
</tr>
</tbody>
</table>

February 2014

Written evidence submitted by Philip Spiers (CB 37)

Care Bill, Part 1, Clause 15

As a person who has been involved with advising older people and their families on obtaining and paying for care for over 20 years and, in doing so, experiencing the shortcomings of a grossly underfunded social care system, I cannot see how the changes to the means test for funding care can help solve the issues this country is faced with. The proposed reforms to the means test for funding care may be seen as diminishing and capping the catastrophic cost of care, however, it also raises more in questions than the answers it sets out to provide.

From the original Terms of Reference of the Commission it was agreed with Government that a new funding settlement should deliver and be:

— Sustainable and resilient: ensuring the costs to the state are sustainable in the long-term, and the care and support system is able to respond to demographic, economic, political, and societal change
— Fairness: for individuals, families, carers and wider society
— Choice: offering an affordable choice to individuals, carers and families across a range of care settings, and helping people to prepare and plan for their future
Value for Money: securing the highest quality care outcomes with the available resources

Ease of use and understanding: making the system as clear and simple as possible for people, supporting people to take responsibility for their future wellbeing.

Although the recommendations, capping of care costs, national assessment criteria, portability of care packages and robust advice and information are all welcomed, it is difficult to see where it contributes towards putting an end to the present crisis of a failing social care system.

On sustainability it has not addressed the issue that we that we have an ever increasing older population and a proportionately reducing working population expected to meet an escalating cost. A high proportion of the present and immediate future generations of older people are property owners and as such can contribute a considerable amount of their accumulated wealth towards their care costs. It should be considered that this may not be the case for future generations less able to purchase property and accumulate wealth.

There still exists the opportunity for Government to be brave and come up with a sustainable funding solution where each generation pays for its own care through a two tier system. For the present and immediate future generations of older people through taxation of assets on death and for the younger generations who have time to accumulate a social care fund a compulsory insurance. In both the opportunity exists to create pots of money that 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. A brief outline of such a system ‘Funding Care: How can each generation pays its fair share? can be found at http://www.jrf.org.uk/publications/funding-care-fair-share

On fairness it keeps to the existing means test rules for home care which means that your home as an asset is disregarded if you are still living in it. If your other liquid assets are below the means test threshold then the local authority will help pay for your care and this contribution will count towards the cap. Is it fair that the state will contribute towards your cap if you need care at home because your housing asset is ignored whereas if you need residential care it is counted and you will have to meet the full cost of the cap from its value? Is it fair that the cost of implementing the proposed reforms are met from general taxation of mainly working people?

On choice, individuals will be limited as to what they can afford. The commission proposes that local authorities will determine the weekly cost of care and this will be the figure used to notionally calculate when the cap has been reached. Typically this could take almost 4 years by which time the individual would have had a cost from capital of circa £60,000. This being considerably higher if they are paying a market rate for their care rather than the arbitrary costs set by local authorities. Even if utilising a deferred payments agreement, homes will still have to be sold to meet this cost. Assuming, local authorities continue to set arbitrary rates for which they are prepared to pay for care considerably lower than the market rate choice on reaching the cap will continue to be determined by how much families can afford to top-up fees.

On value for money and securing the best outcomes with the available resources how can this possibly be achieved if the commission considers that care needs must be substantial or critical before the state steps in. Throughout the country older people with low or moderate care needs have to pay for their own care, rely on family and friends or, do without. This is a false economy and can lead to older people needs and dependency increasing more quickly than they would be if they were supported earlier. Intervention when people have low and moderate needs must prevent many reaching more costly substantial or critical need.

Ease of use and understanding The commission cites that the current system is complex and difficult to understand. Retaining the existing means test rules, albeit with a higher capital threshold and then adding a cap to the cost, surely puts on another layer of complexity.

In conclusion, clearly the proposed funding regime does not resolve the main issues which are that we have an underfunded, under performing social care system on the brink of collapse which cannot and should not be funded by future generations. A funding structure should look at the existing and future demand for care and support, look at unmet need, look at the failings and inconsistencies of the existing system and without the complexities of the proposed charging structure provide an equitable and sustainable solution whereby each generation pays for its own care collectively.

February 2014

Written evidence submitted by Partnership Assurance Group plc (Partnership) (CB 38)

1. Introduction

Partnership

Partnership Assurance Group plc (Partnership) is the largest provider of Long Term Care annuities, also known as Immediate Needs Annuities (INAs) in the UK. We are a specialist provider of financial solutions for people with health and lifestyle conditions, as well as those suffering from a serious medical impairment.
Partnership and Self Funders

Over the last 3 years, Partnership has sought to engage with the Government, charities, the financial services industry, local authorities, care providers and consumers to develop solutions which enable self-funders for care to access specialist care fees advice.

Self-funders are broadly people who have assets (including property) of over £23,250 in England, representing over 43% of people in the care system. In some areas of the country, the majority of people pay for all their care costs—55% in the South East, 53% in the South West and 50% in the East of England. Partnership believes that they are among the most overlooked and underserved people in the care system which they cross-subsidise.

A recent report by the LGiU estimated that 24% of self-funders deplete their assets and fall back on state funding costing councils an estimated £425 million each year in England alone.

Immediate Needs Annuities (INAs)

Partnership is one of only two (soon to be three) companies in the market who provide a product for long term care—this is our INA. INAs guarantee an income for life to fund care costs in return for a one off premium and are designed for adults requiring immediate financial support with their long term care costs. If paid directly to a registered care provider they are tax free. They provide peace of mind for residents and their families because they cover the catastrophic cost of care (as a result of extended longevity) and protect families’ legacies. They are also welcomed by care providers as they cover care costs for life at the private rate and protect Local Authorities for the same reason. The average length of stay in a care home in England is estimated to be around 2.3 years. However, Partnership’s policyholders, who are all self-funders, live on average for 4 years, and 12% live for 8 years or more.

4% of self-funders currently have an INA with an in force market value of £400 million. However, research carried out by the PSSRU\textsuperscript{100} suggests that 40% of self-funders could both afford one and would benefit from it.

2. The Care Bill

Partnership welcomes the Care Bill (‘the Bill’) which aims to bring together “threads from over a dozen different Acts into a single, modern framework” for care and support.

However, there are concerns that the Bill does not go far enough to ensure that, where appropriate, those who have to pay for all or some of their care (‘self-funders’) receive independent regulated financial advice which could help them find solutions to pay for their care needs. We would therefore like to see provision in the Bill for regulations to set out when how local authorities should facilitate access to financial advice regulated by the Financial Conduct Authority (FCA) for those adults likely to benefit from it.

3. Overview

— We welcome the Bill’s requirement for independent general financial advice for all
— However, we believe it is also important that self-funders benefit from ‘regulated’ financial advice
— Regulated financial advice must be delivered by financial advisers with suitable qualifications who are regulated by the Financial Conduct Authority (FCA). Only ‘regulated’ advisers are qualified to provide advice about care insurance products.
— Regulated financial advisers, with the appropriate CF8 qualification, are also able to provide a holistic service and will ask people a number of questions, including, whether citizens have a power of attorney in place; are getting the non means-tested benefits they are entitled to; how they will meet their care funding shortfall (if any); their use of residential home (whether to let or sell it, or as surety for a loan or equity release product) and the shape and type of financial product to meet care fees.
— Our experience has shown us that people should be actively encouraged to get financial advice—simple signposting does not work particularly at times of acute distress.

4. Clause 4: Providing Information and Advice

Clause 4 of the Bill (Providing information and advice) currently makes provisions for local authorities to establish and maintain a service for providing people with information and advice relating to care and support for adults; this must include information and advice on how to access independent financial advice on matters relevant to the meeting of needs for care and support.

Although this is to be welcomed, it is essential that local authorities do not interpret this as a signposting exercise, but instead actively help those who have to fund all or some of their care to seek independent regulated financial advice which will ensure that they are presented with the best options for funding their care needs, and prevent them depleting their assets and falling back on state funding.

Our experience has shown us that people should be actively encouraged to get regulated financial advice as simple signposting does not work, particularly at times of acute distress.

\textsuperscript{100}http://www.partnership.co.uk/Documents/Corporate/PRJimBoydd/Immediate\%20Needs\%20Annuities\%20.pdf
Access to regulated financial advice is important:

It is essential that local authorities facilitate access to regulated financial advice for self-funders so they can make informed choices about how best to pay for their care. With the introduction of a ‘cap’ on care costs meaning that all people who require care will need to approach their local authority to start their care account meter running, this will provide a good opportunity to do so, where appropriate.

While there is a clear need for general financial advice which does not require a regulated independent financial adviser (such as how to access non-means tested benefits and the checking of tax codes etc) which can be obtained through a generic website such as the Money Advice Service—we believe that only ‘regulated’ financial advisers with appropriate qualifications can advise ‘self-funders’ for care on insurance products to help fund care costs.

Regulated financial advice:

Appropriate regulated financial advice is advice which is given by a financial adviser regulated by the Financial Conduct Authority who has at least the CF8 Qualification or equivalent. CF8 is a Chartered Insurance Institute qualification which means that the adviser is able to provide advice and recommendations on long term care.

There is also a ‘gold standard’ for advisers, which goes beyond the CF8 qualification. The Later Life Adviser Accreditation (LLAA), administered by SOLLA (Society of Later Life Advisers), is awarded to individual advisers in recognition of demonstrating best practice, appropriate knowledge and older client procedures.

www.payingforcare.org was established in 2010 to help put self-funders in touch with regulated financial advisers who can help them to identify the best way to fund their care needs. All advisers have the CF8 qualification, and many also have the LLAA.

Where PayingForCare has been involved with local authorities referring through to their designated helpline, it is common practice for adviser panels to provide an initial consultation free of charge.

5. Clause 34: Deferred Payment Agreements and Loans

While the Deferred Payment Agreement is not a financial product, as set out by the Department of Health, Partnership believes that, given it may well be one of the most important financial decisions that an elderly person may have to make in the latter part of their lives, they should in all cases get regulated financial advice. Failure to do so will mean that they might elect for a Deferred Payment Agreement, when a financial product which capped their liabilities in care was the most appropriate choice for them. We are concerned that the failure of local authorities to ensure that this is an appropriately advised decision will leave them open to liability to claims that they have failed to ensure proper and adequate safeguards to vulnerable elderly citizens, who are making this decision at a time which is typically stressful.

6. The Care Bill

Partnership would like to see regulated financial advice included on the face of the Bill. However, we recognise that Earl Howe has stated that advice and guidance under Statutory Instruments is the most appropriate place to give effect to such matters. We would very much welcome this commitment to be delivered.

February 2014