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The Health Committee

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

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, and these can be found in HC 22-II, Session 2009–10. Written evidence is cited by reference in the form 'Ev' followed by the page number; Ev x for evidence published in HC 1021, Session 2008–09, on 13 November 2009, and SC x for evidence to be published in HC 22-II, Session 2009–10.

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Summary

Many people need care and support. Since this cannot always be provided on a voluntary basis by family members and others, there have long been other sources of help. The post-war welfare state promised “cradle-to-grave” care for all according to need and in 1948 the NHS was created to provide healthcare on that basis. However, a deep division was opened up between health and social care.

Unlike healthcare, social care was to be administered by councils, with significant local discretion, and substantially funded from local taxation. There was to be means-testing and charging for care; and it was to be a “safety net” service, predicated on the assumption that care would substantially be provided by voluntary carers. Much has since changed in the adult social care system, which today helps nearly two million people and costs £16 billion a year, but it retains those fundamental characteristics. The system is widely seen as failing and it has long been clear that fundamental and lasting reform is necessary.

Reform is made all the more urgent as an ageing population will mean rising demand for care and support. Projected changes in demographics, availability of support from carers, unit costs of care and other factors indicate that social care in its current form will struggle to meet people’s needs. However, anticipating these factors is a far from exact science. Projections are made from observed trends, based on a series of plausible assumptions, but within a considerable “funnel of doubt”. To minimise doubt, the best possible evidence is needed. However, the Government has been too slow in seeking better evidence regarding healthy life expectancy.

On all reasonable assumptions, the social care system will face considerable increased pressures, but it is important to avoid demographic despair and alarmism. The DH must be careful in presenting data and avoid overstating the case. The demographic challenge is partly a “cohort effect”, caused by the ageing of people born in the post-war “baby boom”. Since the first “baby boomers” will not enter their mid-80s until the early 2030s, there is still a 20-year “window of opportunity” in which to prepare.

Longer life need not mean more time spent in ill health. Improving public health and developing interventions for long-term conditions could pay major dividends. The old-age “support ratio” (the relative numbers of working-age and older people) is not the most important factor in the likely future affordability of social care. Our society must not underestimate its ability to become more productive and wealthier, nor the contribution that older people will make to that.

The shortcomings of the existing social care system provide powerful arguments for reform. Too often people do not receive even information and advice on what help is available. The system is often poorly co-ordinated with other help (not least the NHS and voluntary care). People encounter various forms of rationing, including by eligibility criteria, means-testing and charging, with much local variation. Care can be insufficiently focused on helping people to remain independent and avoid developing greater needs, as well as limited in scope and not always of good quality. In these respects too, there is marked variation between areas. All these factors mean there is a great deal of unmet need.

These shortcomings are all indicative of a system that: provides a “safety net” service, rather than a universal one; is chronically underfunded; and is insufficiently focused on the needs and aspirations of individual people. Pervading the whole system is a persistent ageism; we welcome the fact that the Government and the Equality and Human Rights Commission have finally recognised this and begun to address it but we are appalled it has taken so long.

Social care reform has two interrelated strands: the first is concerned with how care and support are funded and the second with how they are commissioned and provided. When the Government took office in 1997, it stated that the first of these was one of its major priorities. Yet it took until 2009 for the Government to set out a range of options for fundamental reform, in the Green Paper *Shaping the Future of Care Together*. On reforming how care and support are commissioned and provided, the Government has initiated a radical programme of “transformation”. We strongly welcome the focus on personalisation, although there is still a long way to go in realising it.

Shaping the Future of Care Together sets out the Government’s vision for a National Care Service, embodying both strands of reform. We strongly endorse the major elements of this vision which have attracted practically universal consensus:

- a focus on prevention;
- a “portable” national assessment;
- a more joined up service;
- easy access to information and advice;
- personalised care and support;
- a more universal funding system;
- more support for carers;
- building a sound evidence base on different forms of care and support.

However, on other key issues there is still no agreement. Worthwhile and lasting reform will only be achieved if consensus can be reached on these issues too, so that the necessary tough decisions can be taken with broad popular support.

Free care funded from taxation is ruled out by the Government as it would place “a heavy burden” on working-age taxpayers. However, this option has many supporters and most of the arguments against it apply just as much to the idea of a free NHS. The Tax-funded option should be debated to gauge whether people are prepared to pay higher taxes or wish to see tax revenue diverted from other spending.

The DH’s Partnership option supposedly derives from the model developed by Sir Derek Wanless. However, a key part of Sir Derek’s model which is missing from the DH’s is “match-funding”. Sir Derek’s original Partnership option should have been included in the debate.

The DH excludes “hotel costs” from the funding options “because we would expect people

to pay for their own food and lodging whether or not they were in a care home". Yet such costs can be significantly higher in residential care than in a person's own home. Without addressing the risk of uncapped catastrophic costs of this kind, funding reform risks being discredited and losing support. The Government must look at options for dealing with this.

The Green Paper also pays insufficient attention to how the various funding options might affect people of working age with care and support needs.

A major deficiency in the Green Paper is that it is silent on the question of the overall "funding envelope", i.e. how much money overall will be spent on social care in future. This leaves the Green Paper unable to indicate the scope of the new system.

Ahead of fundamental reform, there is scope to mitigate significantly the worst aspects of the existing funding system by means such as raising the capital thresholds in the means test.

We have strong misgivings about the Free Personal Care at Home Bill, which smacks of policy-making on the hoof. This piecemeal reform risks creating perverse incentives and introducing unanticipated consequences. Estimates of demand and cost appear low, and the reform risks being substantially underfunded. The DH has yet to clarify how it will find its share of the funding, except to say some money will come from public health and research budgets, which could be detrimental to the long-term interests of NHS patients.

"Transformation" promises to take social care into uncharted waters and the profound ramifications, and risks, of this need to be fully considered and worked through. There has been confusion about whether the Government is pressing ahead with Individual Budgets (combining various funding streams in addition to social care moneys) or instead adopting Personal Budgets (involving social care funding only). The policy, and the associated terminology, must be made absolutely clear, as well as the basis for whatever decisions are taken.

The apparent goal of bringing together all disability-related expenditure, while giving individual disabled people control of all the sums available to them, has a logic; but it will raise some contentious and difficult issues.

Reforming disability benefits for older people (Attendance Allowance and Disability Living Allowance) by merging them into social care funding is particularly controversial. People with significant needs and modest means could be left worse off. The Government has given assurances that there would be "no cash losers" among existing benefit recipients, but people who develop a care need in future could be worse off than they would have been under the current system.

Personalisation must not be seen as a cost-saving exercise. People who use services must not be turned into rationers of their own care and support.

Not every person who uses social care services will want to take on an entrepreneurial and managerial role as commissioner of their own care and support. The potential of "co-production" (i.e. full partnership between providers and people who use services) to allow personalisation of mainstream services should be fully explored. In some cases it may be appropriate to "ringfence" services such as day centres for people who wish to continue

using them, although outmoded and poor quality services should not be protected.

Information, advice, advocacy and brokerage must be available and must not be funded from people's own resource allocations.

There are concerns about whether councils will have the capacity or the capability to act as effective market managers.

Policies to protect vulnerable adults must be tailored to situations where people are directing their own care and support. Carers must also be protected from unreasonable demands as a result of personalisation.

There are fears about the possible emergence of an unskilled, casualised, unregulated, and potentially exploited, workforce of Personal Assistants (PAs) operating in a semi-informal "grey" market. Local authority "banks" of PAs may be one way of addressing this. There are differing views on whether PAs should be subject to mandatory regulation and vetting. Without a "level playing field" in this respect between PAs and social care staff employed by councils and others, unsuitable staff could migrate from regulated sectors into unregulated PA roles. Nonetheless, many people who employ PAs will insist that they should be able to choose who they wish to work for them. There should be a regulated option for those who wish to use this route, but people who prefer not to use it, and give informed consent to accept the risks that may arise, should be free to do so.

The social care workforce is increasingly in a state of flux. The future role of social workers in particular is still unclear; and plans to extend regulation to the rest of the social care workforce now seem to be in disarray. We are concerned at the apparent lack of an overarching strategic vision for the future social care workforce, and this must be addressed.

We would have liked to see all the political parties come together to map out sustainable reform, instead of indulging in pre-election point-scoring. There is still an opportunity, though, in advance of the demographic challenges to come, to reform social care, achieving consensus and creating a lasting solution.

1 Introduction

The long shadow of the Poor Law has remained over social care to its detriment [...] That long shadow brings with it the armoury of measures we are still familiar with: rationing, eligibility criteria and means-testing to sort out the deserving from the undeserving—Andrew Cozens, former President of the Association of Directors of Social Services¹

1. Many people at some time in their lives need one form or another of care and support. Family, friends and neighbours have always rallied round to provide this but such help can place unrealistic demands on carers and in many cases is simply not available.
2. For centuries people have also relied on other sources of care. In the Middle Ages, charitable hospitals and almshouses gave such assistance; in 1414, the House of Commons declared that the hospitals of England were founded to sustain, among others, “impotent men and women out of their wits and minds”.² Subsequently, care was provided under the Tudor Poor Law and then the New Poor Law of 1834, both of which were founded on a legal presumption of family responsibility. Provision varied greatly from area to area and was too often minimal and grudging, with “indoor relief”³ carrying the stigma of the workhouse.
3. The welfare state which was created in the 1940s, following the Beveridge Report, promised a radical break with the past, undertaking to provide “cradle-to-grave” care for all on the basis of need. This was epitomised by the creation of the NHS in 1948 as a universal, free, tax-funded service, run on a national basis. At the same time, however, a deep division was opened up for the first time between health and social care.
4. The social care system which was created under the National Assistance Act 1948 did not represent a complete rupture with the past and still bore significantly the imprint of the Poor Law. In contrast to the NHS, social care was to be administered by councils, with significant local discretion, and substantially funded from local taxation. There was to be means-testing and charging for services. It was a residual or “safety net” service, predicated on the assumption (if not a legal presumption, as under the Poor Law) that care would as far as possible be provided by family members and other voluntary carers.⁴ Many things have changed in social care over the past six decades, but the system today still retains those fundamental characteristics, which are increasingly ill-suited to modern needs and expectations.⁵

1 “Poor Law mentality must end”, *Community Care*, 23 October 2003

2 Nicholas Orme and Margaret Webster, *The English Hospital, 1070–1570* (New Haven CT, 1995), p 119. The “impotent” included frail older people and disabled people.

3 “Indoor relief” was assistance given to the poor (including the “impotent”) on condition of entering a workhouse (as opposed to “outdoor relief”, whereby assistance as given, in cash or kind, to people living in their own homes).

4 In addition, sections 42 and 43 of the 1948 Act still gave local authorities the discretionary power to ask the spouse of a resident of a care home to make payments towards the cost of that residential care in addition to any sums already being collected from the resident for this purpose (the “liable relatives rule”). This particular Poor Law anachronism was only repealed in April 2009, under the Health and Social Care Act 2008.

5 We are grateful to Professor Pat Thane, of History & Policy, for providing us with an historical overview of social care (Ev 148–153).

5. Every year, nearly two million adults in England use social care services provided by their local council or commissioned on their behalf but more than 150,000 older people must purchase community support privately and almost 120,000 pay privately for places in care homes. At the same time millions of carers provide an immense amount of support with little or no help from the state and many thousands of people may be in need of help which they simply cannot obtain from any source. The system is widely seen to be failing and it has been clear for a long time that fundamental and lasting reform is necessary. The need for reform is made all the more pressing as an ageing population brings the prospect of rising demand for care and support.

6. In September 1997, the then Prime Minister told the Labour Party conference: “I don’t want [our children] brought up in a country where the only way pensioners can get long term care is by selling their home”.⁶ Subsequently, the Government appointed a Royal Commission on Long-Term Care, under Sir Stewart (now Lord) Sutherland, which reported in 1999 and made far-reaching recommendations on reforming the approach to paying for long-term care. However, the core recommendation, the introduction of free personal care, was not accepted by the Government (although it was implemented by the devolved administration in Scotland). In 2006, pressure for reform increased when Sir Derek Wanless published his review of social care for the King’s Fund, proposing a “partnership” funding model as the way forward.

7. In July 2009, the Government finally published a Green Paper, *Shaping the Future of Care Together*. This recognised the need to reform the current system of care and support in England, both to respond to demographic change and also to establish a more personalised and equitable service. For some time we had wanted to examine social care, but we decided to wait until the Government published its Green Paper. When it finally appeared, with a consultation period which was to run until 13 November 2009, we announced our inquiry. Our terms of reference were to look at options for:

- future funding of long-term residential and domiciliary care for older people and people with physical or learning disabilities;
- personalisation of social care services;
- more effective, consistent and user-friendly social care services.

8. There was surprise when, during our inquiry and while consultation on the Green Paper was still continuing, the Prime Minister announced to the Labour Party conference a policy for free personal care at home which appeared to cut across the Green Paper proposals. Fortunately, we were able to question witnesses about the Prime Minister’s proposals in our oral evidence sessions.

9. We received memoranda of written evidence from 61 bodies and individuals. We held a total of seven oral evidence sessions, hearing from academic and other experts on demography, social care funding and social policy; Baroness Young of Old Scone, the then Chairman of the Care Quality Commission; UNISON, the trade union representing many social care workers; the General Social Care Council; the Social Care Institute for

6 Speech by Rt Hon Tony Blair MP to the Labour Party Annual Conference, 30 September 1997

Excellence; Skills for Care; representatives of independent sector social care providers; a representative of the insurance industry; advocacy groups representing people who use social care services and carers (Age Concern and Help the Aged, Counsel and Care, the Alzheimer's Society, Mencap, Mind, the Multiple Sclerosis Society and Carers UK); In Control, which is developing and promoting self-directed care; the National Director for Social Care Transformation; the President of the Association of Directors of Adult Social Services; and the Vice-Chair of the Local Government Association. We also took evidence from Rt Hon Andy Burnham MP, the Secretary of State for Health, along with officials from the Department of Health and the Department for Work and Pensions. We would like to thank all who gave evidence to us and our specialist advisers, Melanie Henwood OBE, an independent social care consultant, and Dr José-Luis Fernández, of the Personal Social Services Research Unit at the London School of Economics, for their expertise in helping us navigate the complexities of this difficult subject.⁷

10. In the report below we look at:

- The present social care system;
- Meeting future demand and costs;
- Shortcomings of the present social care system;
- Plans for reform;
- Achieving lasting reform; and
- The way forward.

⁷ Ms Henwood declared her interest as Vice Chair of the General Social Care Council, Chair of the Advisory Group on Independent Living to the Multiple Sclerosis Society and a former member of Sir Derek Wanless's social care review team. Dr Fernández declared his interest as a former member of the Wanless team and the HM Treasury review of long-term care funding, as well as a current member of the King's Fund team updating the Wanless review and an adviser providing policy and quantitative analytical support to the Department of Health on social care funding.

2 The present social care system

11. Before we turn to examine the shortcomings of social care and current proposals for reform, it is important to understand the nature and broad characteristics of the present system. In this chapter we consider:

- What are social care services and who are they for?
- Who is responsible for social care services?
- How is social care funded?
- What duties and powers do local authorities have?

What are social care services and who are they for?

12. Traditionally, social care needs have been identified by classifying people according to:

- frailty or infirmity relating to age;
- physical disability;
- learning disability (developmental disorders involving intellectual impairment, e.g. Down's Syndrome);
- functional mental illness (involving a disorder of the mind, e.g. schizophrenia or bipolar disorder);
- organic mental illness (resulting from physical impairment of the brain, e.g. dementia or brain injury).

Social care services have conventionally sought to meet care and support needs through publicly provided or commissioned residential and non-residential services, the latter including domiciliary care, meals-on-wheels and day centres (see Annex 1).

13. In recent years, however, these ways of understanding and organising social care have been strongly criticised by people who use services themselves. Traditional services, and categorisations of people who use services, have been recognised as often unhelpful, and even counterproductive, in addressing people's actual needs and preferences. In response to this critique, and reflecting shifts in political thinking about public service delivery, new approaches to providing social care have been introduced as part of "personalising" care and support (this is explored more fully in Annex 2).

14. The Department of Health (DH) now uses a broad "enabling" (as opposed to prescriptive) definition of social care as:

the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships⁸

Since 1997, some groups of people who are eligible for social care have been able to choose to receive Direct Payments, i.e. cash sums that they can use to meet their needs, in lieu of non-residential services that are publicly provided or commissioned. These payments are often used to employ Personal Assistants (PAs), who help in a wide range of ways with care and support needs. Further innovations that allow greater choice and control for people who use services are also being rolled out, notably Individual Budgets and Personal Budgets, (giving people control over the budgets allocated for their care and support, without necessarily receiving cash payments). At present, these alternative modes of social care provision only exist on a relatively small scale, but they are seen as having the potential to transform beyond all recognition the landscape of social care, as we discuss in detail in this report.

15. Official data returns for adult social care in England show that in 2008–09:

- a total of 1.78 million people received care and support;
- 1.54 million people received non-residential care and support;
- 319,000 people received residential care services;⁹
- 86,000 social care clients received a Direct Payment;
- 28,000 carers of adults aged 18 and over received a Direct Payment.¹⁰

16. This publicly-organised social care is modest in scale compared to the very large amount of care and support provided by “carers”, i.e. people who provide unpaid, voluntary care and support, such as spouses, partners, family members, friends or neighbours.¹¹

Who is responsible for social care services?

17. Adult social care falls within the statutory remit of the 152 Councils with Adult Social Services Responsibilities (CASSRs),¹² an arrangement that dates back to the National Assistance Act 1948.

8 Department of Health, *Our health, our care, our say: a new direction for community services*, Cm 6737, January 2006, para 1.29. Adults social care helps people aged 18 and over. The term “community care” was widely used in the past to describe social care but it is less common now, although it remains embedded in social care legislation.

9 These are provisional data. There is an element of double-counting within and between the categories of non-residential and residential care recipients, as some people will have used more than one type of service during the year; the total figure for all care recipients (1.78 million) does not include any double-counting (Health and Social Care Information Centre, *Community Care Statistics: Social Services Activity, England – Councils with Adult Social Services Responsibilities tables, provisional, 2008–09*).

10 HC Deb, 18 January 2010, col 115W

11 The term “informal care” is often used to describe this, but it is not universally accepted.

12 CASSRs are enumerated as follows: Unitary Authorities (55); Metropolitan Boroughs (36); London Boroughs (32); County Councils (27); the City of London Corporation; and the Council of the Isles of Scilly.

How is social care funded?

18. In 2008–09 total gross current (i.e. non-capital) expenditure on Personal Social Services (PSS)¹³ amounted to £16.1 billion.¹⁴ This represents an increase of over £791 million on the 2007–08 figure of £15.3 billion (approximately 3% in real terms).¹⁵ Overall gross expenditure on adult PSS rose in real terms by 57.4% between 1997–98 and 2007–08.¹⁶ This is in contrast to spending on the NHS, which doubled in the same period; however, social care is funded on a different basis to the NHS, through a mixture of local and (mostly non-ringfenced) national sources, as we explain below.

Funding from central government

19. Most funding for social care comes from central government through the (non-ringfenced) Revenue Support Grant (RSG).¹⁷ Central Government also pays specific grants, which are now mostly included in the Area Based Grant. The RSG allocation for each council is calculated using Relative Needs Formulae (RNFs). The RNF for older people's social care takes account of social structure, area costs, levels of deprivation and numbers of older people (particularly the “older old”, aged 80 or over).

20. Overall, total Aggregate External Finance (AEF) for local authorities (i.e. all moneys distributed to them by central government) rose by 4.2% in 2009–10. The AEF increase for 2010–11 will be 4%; grants to local government will then have risen in real terms by 48% since 1997–98.¹⁸ However, it is clear that, given the current state of the public finances, settlements for some years thereafter will be much less generous.

Local sources of funding

21. A substantial proportion of social care spending comes from finance raised by councils themselves. The Local Government Association (LGA) told us that in 2008–09 councils' combined net contribution to social care spending amounted to £5.3 billion (i.e. 32.9% of the provisional total gross current expenditure), with some councils spending more on social care than the value of their entire RSG.¹⁹ Councils do, though, differ significantly in their willingness and ability to raise revenue for this purpose. Most of the funds raised locally for social care come from levying Council Tax, subject to the constraints imposed by the Government's power to “cap” Council Tax increases.²⁰

13 The term “Personal Social Services” mainly encompasses social care, but also includes other services. It is generally considered anachronistic but remains in administrative use.

14 Provisional data from the National Adult Social Care Intelligence Service, nascis.ic.nhs.uk

15 Health and Social Care Information Centre, Personal Social Services Expenditure and Unit Costs, England Provisional 2008–09; cf. Q 3

16 Health Committee, *Public Expenditure on Health and Personal Social Services 2009*, HC (2009–10) 269–i, Table 34b

17 RSG is paid as part of the Formula Grant, along with National Non-Domestic Rates (a business tax that is levied nationally and then allocated to local authorities on a capitation basis).

18 Calculation by the House of Commons Library, using data from the Department for Communities and Local Government

19 Ev 26

20 Central Government allocations to local authorities are adjusted (by means of calculating Relative Resource Amounts) to take account of local authorities' differing abilities to raise money from local taxation on account of

22. Local authorities have a good deal of choice in how they spend their available funds, subject to the government spending cap,²¹ as well as requirements on spending ringfenced government grants and meeting statutory obligations (which only apply in limited ways to social care). There are many competing claims on council budgets and the amount spent by each local authority on social care will to a large extent reflect how much priority it is given.

23. Councils can offset significant amounts of their gross expenditure on social care by levying charges on some people who use services, subject to the constraints imposed by national rules. This is discussed further below.

What duties and powers do local authorities have?

24. Local authorities have certain statutory duties and powers regarding: the provision of information; the assessment of need for social care services; and the provision of support to people who meet local eligibility criteria.

Provision of information

25. Councils have a legal obligation to provide information about non-residential services. In cases where people are not able to access council-arranged services, local authorities are expected to signpost appropriate alternative provision.

Assessment of presenting needs

26. Each CASSR has a statutory duty to carry out an assessment of a person's "presenting needs" for social care services in certain circumstances.²² There is also a duty to notify NHS and housing support authorities, and to invite them to take part in the assessment process where it appears there may be a need for their services. In addition, carers aged 16 or over who are caring for a person aged 18 or over who uses social care services are entitled to a separate assessment of their ability to provide, or continue to provide, care.

Assessment of eligible needs

27. Councils have the discretion to determine which needs are "eligible needs", i.e. which level of need will qualify a person to receive care and support. Since 2003, eligibility has been assessed by councils according to a set of four standard threshold criteria, laid down in mandatory Fair Access to Care Services (FACS) guidance (see Box 1). This was issued by the DH partly in response to concerns about the perception of unfair and unjustifiable variations between local areas (often referred to as a "postcode lottery").

varying local taxbases. The Government has deemed that, in 2009–10, any Band D Council Tax increase of more than 5% is excessive.

21 The Government's capping regime limits budget requirements (i.e. spending financed by Formula Grant and Council Tax). In 2009–10, authorities' requirements have been deemed excessive if they set an increase of more than 4%.

22 The circumstances are where: the person appears to be someone for whom social care services could be provided; and the person's circumstances may need the provision of some social care services.

Box 1: Summary of Fair Access to Care Services standard threshold criteria

- 1) **Critical** – where life is in danger, or serious abuse or neglect has occurred or might occur;
- 2) **Substantial** – where abuse or neglect has occurred or might occur, or the individual is unable to carry out the majority of personal care (i.e. activities such as washing, dressing, going to the toilet, eating, etc.) or domestic routines and there is no-one available to assist;
- 3) **Moderate** – where the individual is unable to carry out several personal care or domestic routines, or several of their family and social roles;
- 4) **Low** – where the individual is unable to carry out one or two personal care or domestic tasks, or one or two of their family and social roles.

28. The FACS guidance does *not*:

- prescribe which needs should be regarded by councils as eligible;
- require councils to make identical decisions about a particular person's level of need (should someone present for care and support in more than one council area); or
- prescribe what services should be available to people with similar levels of need.

Provision of services

29. Where eligibility criteria are met, councils have a duty:

to provide residential accommodation for persons aged 18 or over who by reason of age, illness, disability or any other circumstance are in need of care and attention not otherwise available to them.²³

In addition, councils have the power under the 1948 Act to arrange or provide non-residential services as they think appropriate for adults:

who are blind, deaf, or dumb, or who suffer from mental disorder of any description, and other persons aged 18 or over who are substantially and permanently handicapped by illness, injury, congenital deformity or such other disabilities as may be prescribed by the Minister.²⁴

There are also some statutory obligations in this regard under the Act and subsequent legislation. In respect of each person for whom care and support are to be commissioned or provided, a written Care Plan should be prepared.

²³ National Assistance Act 1948, section 21

²⁴ *Ibid.*, section 29

30. In providing non-residential care and support, councils are required to offer Direct Payments in lieu of any social care services to meet the assessed needs of people, provided they have been assessed as willing and able to manage Direct Payments (either alone or with support). Direct Payments cannot be used for:

- services provided directly by the local authority itself;
- permanent residential accommodation;
- employment of a spouse/partner or co-resident family member;
- any spending that is not intended to meet the assessed needs of the person using the service.

Means-testing and charging

31. Unlike healthcare, social care services are subject to means-testing and charging. This particularly affects services for older people, where £1.8 billion (20% of gross expenditure) was recouped in client contributions (made up mainly of charges)²⁵ in 2008–09 (compared to around 6% of gross expenditure on services provided to working age adults).²⁶ The regimes under which this occurs differ between residential and non-residential services, as we outline below.

Means-testing and charging for residential care

32. There are statutory national rules, which originated under the 1948 Act, concerning means-testing and charging for residential care services.²⁷ Each local authority has a “standard rate”²⁸ it will pay when it places a person in residential accommodation, according to the type and level of care needed. This sum covers personal care and “hotel costs” (i.e. accommodation, food, laundry, etc.).²⁹ The council is required to carry out an assessment of the resident’s financial means (both assets and income), charging them such sums as they are liable to pay.

33. The means test relating to assets covers cash, investments, property (including equity in the resident’s own home) and other capital. For the first 12 weeks after entry into a care home, the value of a person’s principal property is not included in the means test (i.e. it is “disregarded”). Thereafter, it is included, except where a current spouse/partner or other qualifying person³⁰ continues to live there, in which case it continues to be disregarded.³¹

25 Client contributions also include a small amount of revenue raised through sales and fees.

26 Provisional data from the National Adult Social Care Intelligence Service, nascis.ic.nhs.uk. Central government allocations to local authorities are adjusted, by means of the Low Income Adjustment in the Social Services for Older People RNF, to recognise authorities’ differing abilities to raise income from charges.

27 These rules are now embodied in the National Assistance (Assessment of Resources) Regulations 1992 and the Charges for Residential Accommodation Guide.

28 This is also sometimes called the “usual cost”.

29 Nursing care provided as part of a package of care in a nursing home is paid for by the NHS.

30 Other qualifying persons are: a person under the age of 16 whom the property owner is liable to maintain; a close relative over the age of 60; a close relative under the age of 60 who is disabled; or an estranged partner who is a lone parent.

34. A person with total (non-disregarded) assets worth more than a given capital threshold (this is uprated annually and in 2009–10 stands at £23,000) receives no public financial support. In this case, the resident must pay the full standard-rate amount for their council-arranged care (i.e. pay a 100% charge); or they can choose to make their own private arrangements (usually known as “self-funding”). The resident will only qualify for public support when the value of the assets has been spent down to the level of the disregard threshold. This often means that property has to be sold and much of the proceeds spent on paying for residential care.

35. People with assets below the £23,000 threshold (in 2009–10) receive public support, but are required to pay almost all of their “assessed income” in charges. All pension income (both state and private)³² and most social security benefits³³ are included in the assessed income. For people with assets below the £23,000 threshold and above a lower capital threshold (this is also uprated annually and in 2009–10 stands at £14,000), a “tariff income” is assumed from capital above the lower limit. Currently (in 2009–10) the rate for this is set at £1 per week for every £250 or part thereof.³⁴

36. The only part of assessed income that does not have to be paid in charges is a modest weekly Personal Expenses Allowance (PEA); this figure too is uprated annually and in 2009–10 stands at £21.90.³⁵ The DH states that the PEA “is intended to enable residents to have money to spend as they wish, for example on stationery, personal toiletries, treats and small presents for friends and relatives”.³⁶

Means-testing and charging for non-residential care

37. Councils have the power to means-test and charge for non-residential care as they see fit, within the Fairer Charging guidelines issued by the DH in 2003. These state that any capital threshold for the purpose of means-testing for domiciliary care should not be lower than that for the residential care means test (as outlined above). Equity in a person’s principal property (i.e. the value of their home) cannot be included in the means test for non-residential care, in contrast to the means test for residential care.

38. The guidelines also specify that a user’s assessed net income after care charges must not fall below a minimum threshold; and they forbid charging a minority of people who use services who fall into certain categories. There is a great deal of variation between local authorities in their operation of charging for homecare services. A small number of councils choose to provide free services for all or for certain groups of people. Some charge a flat rate (i.e. it applies to all, irrespective of relative ability to pay) to those who fail the

31 Councils also have discretion to disregard the value of a property if a carer is still living in it when the owner moves into a care home.

32 Half the value of a private pension is disregarded if it is being paid to a spouse or civil partner who is not living in the same care home.

33 The mobility component of Disability Living Allowance is excluded from the means test.

34 The tariff income formula is not intended to represent any actual rate of return that could be obtained from investing or depositing capital at current interest rates. It is an administrative device for setting user charges applicable to people with a certain level of assets.

35 A resident would only be completely absolved from paying charges if their income were below the level of the PEA; but this should not happen if Pension Credit is claimed from the Department for Work and Pensions.

36 www.dh.gov.uk/en/SocialCare/Chargingandassessment/ChargingforSocialCare/DH_079505

means test; this is a highly regressive policy, imposing the greatest relative burden on those who are relatively worst off. Most councils, however, levy “stepped” charges, with a series of means thresholds to take account of relative ability to pay.

39. As this chapter has shown, the social care system is complex and confusing. This system is likely to come under increasing pressure to meet people’s needs as a result of anticipated changes in demand and costs. In the next chapter we consider the evidence for this and its implications for the future of social care.

3 Meeting future demand and costs

40. Projected changes in the demand for, and cost of, social care services indicate that the care and support system in its current form will struggle to meet people's needs. Those changes relate to:

- demographics;
- availability of support from carers;
- unit costs of care; and
- other factors.

In this chapter we examine each of these and their potential impact.

Demographics

41. The DH states in the Green Paper *Shaping the Future of Care Together* that:

In 20 years' time, we expect there to be 1.7 million more adults needing care and support than there are now, and proportionately fewer people of working age to help pay for the funding of that care and support.³⁷

This statement rests on projections showing that England's population is ageing (i.e. the number of older people is increasing in absolute terms, and older people form a growing proportion of the population) but without necessarily becoming healthier. In the following sections we consider whether the DH's view of the future is soundly based.

Increasing numbers of older people

42. The most recent official population projections³⁸ show that the numbers of the "oldest old" are projected to increase in the coming decades. According to these projections, the number of people aged 85 or over will almost double between 2010 and 2026, rising from 1.2 million (2.3% of the population) to two million (3.5% of the population).³⁹ The increasing absolute number of older people is substantially down to rising average life expectancy,⁴⁰ i.e. people now are on average living longer than people did in the past.

43. In the Green Paper the DH says:

37 Department of Health, *Shaping the Future of Care Together*, Cm 7673, July 2009, p 99

38 A population projection is not a forecast or prediction. Rather, it sets out what the population will be in future, based on observed trends (in mortality, fertility and migration), if certain assumptions are made about the likely continuation of those trends. Projections consist of a principal projection, and a number of variants, showing the effect of making alternative assumptions about the continuation of current trends.

39 Office for National Statistics, 2008-based National Population Projections (Principal Projection). Over the same period, the number of centenarians (people aged at least 100) is expected almost to quadruple, rising from 10,000 (0.02% of the population) to 35,000 (0.1 % of the population).

40 Life expectancy is the average statistically expected further years of life at particular ages, calculated using age-specific mortality rates (rates of death at particular ages).

In 1948, when the welfare state was founded, society looked very different. A boy born at that time could expect to live to 66; a boy born today, in 2009, can expect to live to over 78.⁴¹

David Behan, the Director General of Social Care at the Department, similarly told us that:

Life expectancy for a man was 66 in 1948—basically, you worked until you were 65, you had a year and you died—whereas now life expectancy for a man is well into the seventies, 77 [the correct age is actually 78, as stated in the Green Paper] [...]⁴²

While the available data do clearly show that life expectancy has increased significantly since 1948, both these statements are, unfortunately, somewhat misleading in their presentation of the data, as we heard from another witness.⁴³ It is not true to say, as the Green Paper effectively suggests, that the majority of males born in 1948 will be dead by 2014.⁴⁴ Nor is it true, as Mr Behan suggested, that a man who turned 65 in 1948 could expect on average to be dead within a year; in fact, he could have expected to live to the age of 78.⁴⁵ The data cited by Mr Behan relate to life expectancy *at birth* rather than life expectancy *at age 65*. There was a significant gain in life expectancy at age 65 between 1948 and 2009 (amounting to 5.3 years), but it was less dramatic than the gain in life expectancy at birth over the same period referred to by Mr Behan (which amounted to 12.0 years).⁴⁶

44. The impact of increasing life expectancy will inevitably be amplified by the fact that a significant demographic “bulge” of people born during the post-war “baby boom”⁴⁷ is now approaching older age. The projected growth in numbers of older people is thus partly a transient phenomenon (a “cohort effect”), a point that the DH does not seem to be explicitly acknowledging. This will not significantly affect the demand for social care until the early 2030s, when the first “baby boomers” enter their mid-80s. It thus remains the case that, as our predecessor committee noted in 1996, there is a “window of opportunity” in

41 Department of Health, *Shaping the Future of Care Together*, Cm 7673, 2009, p 32; cf. p 38

42 Q 4

43 Qq 151–152

44 The data cited by the Department relate to *period* life expectancy, which is calculated using the age-specific mortality rates (i.e. rates of death at particular ages) for a given period in time. It provides a useful way of summarising mortality rates during a specific time, but it does not reflect how long a particular person could expect to live, since it makes no allowance for changes in future actual or projected mortality rates as that person ages. The appropriate data to have cited would have been those relating to *cohort* life expectancy. This is derived from age-specific mortality rates in an actual cohort of population (a group of people born in a particular time period) as it ages, rather than being read off from the mortality rates observed in a particular “slice of time”. It is calculated using known or projected mortality rates as the cohort ages and, therefore, reflects the actual length of time a person could expect to live.

45 These data apply to England and Wales (Office of Health Economics, “The Economics of Health Care”, www.oheschools.org/ohesch6pg4.html).

46 *Ibid.*; Office for National Statistics, *Period expectation of life (years), England*, Based on historical mortality rates from 1981 to 2008 and assumed calendar year mortality rates from the 2008-based principal projections. These gains relate to *period* life expectancy. Over the past century, gains in life expectancy at birth (driven by steep falls in infant mortality) have been substantially greater than those at later ages. While gains in life expectancy have continued at all ages, gains at birth have slowed since the 1960s; by contrast, gains at age 65 have accelerated, although they are now beginning to level off.

47 The baby boom was a period of increased births (associated with increased fertility rates) which occurred between the mid-1940s and the mid-1960s, with significant peaks in 1947 and 1964.

which to prepare the social care system for the onset of significant demographic challenges in the middle years of the 21st century.⁴⁸

Population ageing

45. As well as increasing in absolute numbers, older people form an increasing proportion of the overall population, i.e. the average age is increasing, meaning that the balance between older and younger people is shifting towards the former. This phenomenon is known as “population ageing” and is a long-term trend characteristic of all developed countries.⁴⁹ It is evident in the latest population projections for England, which expect the population aged over 65 to rise from 16% in 2010 to 20% by 2026.⁵⁰

46. The trend to population ageing is being amplified by the “cohort effect” of the baby-boom generation ageing. This is compounded by the effect of the “baby bust” or “birth dearth” that followed the baby boom, in which fertility rates fell significantly.⁵¹ Recent increases in fertility and significant inward migration have slowed the trend towards population ageing, but only slightly.

47. Population ageing is often said to have significant implications for the future of social care, and other tax-funded services, since it entails a shifting balance between the working-age population (aged 18–65) and the population over working age (aged 65 and over). This is generally referred to as the old-age “support ratio” or “dependency ratio”. James Lloyd, Senior Research Fellow at the Social Market Foundation, told us:

we do have an ageing population, we do have a declining elderly support ratio, so simply to maintain spending on the NHS and the state pension at equivalent levels today will mean that the tax burden will have to increase, so it will mean that income taxes will have to increase regardless of what we do to social care. People particularly who are now in their twenties and thirties will necessarily have to face higher income tax over their lives, if we are just to maintain spending on the NHS and state pension.⁵²

48. However, Mr Wittenberg told us that the dependency ratio was of limited use:

Clearly when one is looking at long-term care demand one has to go rather deeper than that and realise several things. One is that 40% of the gross expenditure on social care actually relates to people below 65. Secondly, of the 60% that relates to people above 65, the vast majority actually relates to people above 75 and in many

48 Health Committee, Third Report of Session 1995–96, *Long-term care: Future provision and funding*, HC 59–I, para 120

49 Population ageing has been driven by a persistent long-term combination of increasing longevity (with life expectancy rising first at younger ages and then at older ages too) and lower fertility rates than in pre-industrial societies. The observed process of change from high birth rates and high mortality at younger ages to low birth rates and low mortality at younger ages is known as the “demographic transition”. It has included a transitory phase in which changes in birth rate lagged behind changes in mortality, leading to a period of high birth rate and low mortality at younger ages, resulting in population growth. Population ageing has been less marked in the UK than in much of the rest of Europe.

50 Office for National Statistics, 2008-based Principal National Population Projections, England

51 By the 1970s the fertility rate was below the replacement rate (i.e. that needed to ensure the continuation of the existing level of population) and it has remained there for over a generation.

52 Q 253

cases even older than that. I find the dependency ratio perhaps very useful as a headline starting figure but clearly in doing detailed work we need more detail. In addition it has been pointed out that there are plenty of people working beyond state pension age and there are plenty of people who have retired before it.⁵³

Future levels of disability

49. In the current population the likelihood of needing care and support escalates sharply with age.⁵⁴ Whether extra years of life gained by increasing life expectancy are lived relatively free from illness or disability is a crucial determinant of future levels of need for care and support. This is commonly discussed in terms of “healthy life expectancy” (expected years of life in good or fairly good health at given ages) and “disability-free life expectancy” (expected years of life without a limiting illness or disability at given ages).

50. Several future scenarios are possible in the relationship between life expectancy and healthy life expectancy / disability-free life expectancy at older ages, including:⁵⁵

- **“Compression of morbidity”**⁵⁶ (the optimistic scenario): healthy life expectancy advances at the same rate as, or faster than, life expectancy, leading to less dependency overall.
- **“Expansion of morbidity”** (the nightmare scenario): healthy life expectancy advances significantly more slowly than life expectancy, stays the same, or even recedes, so there is more dependency overall.
- **“Dynamic equilibrium”**⁵⁷ (the steady-state scenario): healthy life expectancy advances marginally more slowly than life expectancy, or light-to-moderate disability increases while severe disability decreases, so the overall impact on the level of dependency is marginal.

51. The calculations of future social care need used by the DH draw on research by Carol Jagger, Professor of Epidemiology at the University of Leicester.⁵⁸ She told us that she did not subscribe to the “compression of morbidity” thesis in respect of this country, although

53 Q 191

54 As at April 2009, 15.8% of the UK population aged 85 or over (the “oldest old”) were resident in a care home or long-stay hospital, compared to 4.0% of those aged 75–84, 0.8% of those aged 65–74, and 0.04% of those aged under 65 (Laing & Buisson, *Care of Elderly People: UK Market Survey 2009*, pp 18–19).

55 *Healthy life expectancy*, POSTnote 257, Parliamentary Office of Science and Technology, February 2006; Raymond Tallis, “The ultimate aims of medicine and the future of old age”, *Asian Journal of Gerontology and Geriatrics*, vol 1 (2006), pp 157–162; Carol Jagger *et al.*, *Compression or Expansion of Disability?: Forecasting Future Disability Levels under Changing Patterns of Diseases* (London, 2006)

56 As part of the demographic transition, industrial societies have already experienced a “compression of mortality”, i.e. the concentration of the majority of deaths into an increasingly narrow set of older age bands, as a result of age-specific mortality rates falling more steeply in younger ages than in older ones. More recently, industrial societies have also experienced falling age-specific mortality rates at older ages, so over time the majority of deaths are occurring in increasingly older age bands. The “compression of morbidity” thesis holds that this will also become the case in respect of illness and disability, as part of a “health transition” akin to the “demographic transition”.

57 A system characterised by “dynamic equilibrium” is one in which different inputs change in such a way that the changes cancel each other out, leading to no overall change in outputs.

58 Qq 918–920

she admitted that the amount known is “Not as much as we would like”⁵⁹ and “The data we have is rather mixed”.⁶⁰ She explained that:

In this country we do not have any really good cohort data like some other countries such as Denmark and Sweden have. We are in the process of getting that; there is a study in the field at the moment which will address that much better than we have done before. However, there does not seem to be any indication that the years of disability are reducing very much.⁶¹

52. The currently available data on healthy life expectancy at age 65 are published by the Office for National Statistics (ONS) and indicate mixed conclusions regarding current trends.⁶² These are *period* data based on “snapshot” General Household Survey (GHS)⁶³ questions about self-reported illness and disability; *cohort* data, by contrast, relate to a particular group of people over time, giving a much better idea of actual trends. It is noteworthy that the need to commission better data on healthy life expectancy was pointed out as long ago as 1996 by one of our predecessor committees.⁶⁴ This was echoed in 1999 by the Royal Commission on Long-Term Care, which specifically recommended setting up a longitudinal study,⁶⁵ as did the House of Lords Science and Technology Committee in 2005.⁶⁶

53. The study referred to by Professor Jagger is part of the Cognitive Function and Ageing Study, funded by the Medical Research Council.⁶⁷ The English Longitudinal Study of Ageing (ELSA) is also collecting data on illness and disability (only partially on a self-reported basis) from a group of people over time and will in due course generate cohort data.⁶⁸

54. Professor Jagger cited examples of specific conditions where she thought evidence tended to contradict the “compression of morbidity” thesis. She told us, for example, that mortality rates for major conditions such as coronary heart disease and stroke were improving:

59 Q 155

60 Q 156

61 Q 155

62 Michael Smith, Grace Edgar and Genevieve Groom, “Health expectancies in the United Kingdom, 2004–06”, *Health Statistics Quarterly* 40 (2008), pp 77–80

63 The GHS is a multi-purpose continuous survey that collects information on a range of topics from people living in private households in Great Britain. It is carried out on annual basis by the Social Survey Division of the Office for National Statistics, and has been run every year since 1971 (except in 1997–8 and 1999–2000). The name of the GHS has recently been changed to the General Lifestyle Survey, and it now forms part of the Integrated Household Survey.

64 Health Committee, *Long-term care: Future provision and funding*, para 97

65 Royal Commission on Long-Term Care, *With Respect to Old Age: Long Term Care – Rights and Responsibilities*, March 1999, para 2.24 (recommendation 2.2)

66 House of Lords, *Ageing: Scientific Aspects*, First Report of the Select Committee on Science and Technology, Session 2005–06, HL Paper 20–I, paras 2.29–30, 36

67 www.ncl.ac.uk/ihs/research/project/2710

68 James Banks, Elizabeth Breeze, Carli Lessof and James Nazroo (eds.), *Living in the 21st century: older people in England the 2006 English Longitudinal Study of Ageing (Wave 3)* (London, 2008), Ch 8

but all that means is that we are keeping more people alive who have the disease as opposed to actually stopping people having the disease to begin with. More people are living with disease now.⁶⁹

She also told us that, while the increasing rate of obesity might lead to more premature death at younger ages, “Obesity does not have a huge effect on mortality; it has a much greater effect on disability”.⁷⁰

55. We asked several witnesses about the potential for future scientific advances to help limit the level of social care need associated with various conditions. One factor in the anticipated increase in demand for social care services is the extension of life expectancy for people with a learning disability. Whereas a person with Down’s syndrome would once not have been expected to live beyond their mid-20s, now they are often living well into their 50s and beyond. More people with profound and multiple learning disabilities are now surviving into adulthood, often with increasingly complex needs associated with multiple conditions and the development of early dementia.⁷¹ In this case, scientific breakthroughs cannot be ruled out, but they do not seem probable, as we heard from David Congdon, Head of Campaigns and Policy at Mencap:

it is unlikely—but one can never predict the future—that there are medical solutions of any shape or form to learning disability as a generality and, therefore, the idea that advances in medical science of any shape or form or genetics will lead to a significant reduction in the demands in terms of social care for people with a learning disability I do not think are valid, to be perfectly frank.⁷²

56. Regarding degenerative conditions, such as Multiple Sclerosis (MS), Stuart Nixon, Vice Chair of the Board of Trustees of the MS Society, told us that at least the management of such conditions could change:

we have moved in the last 20 years from what was effectively a diagnosis service, “Go away and live with it,” to something where hopefully in the next five years or so there will be a range of disease modifying therapies. None of these are a stepping back on the line of disability that you have gone down, but they are hopefully about arresting that progression [...] There are some positives, but by no means are we looking at something that within the foreseeable future is going to change.

Q726 Jim Dowd: The impact on the pressure for social care will be minimal?

Mr Nixon: Yes. We do not see it having an enormous effect.

57. A large proportion of anticipated future care need is associated with substantial numbers of people being affected by dementia. The Alzheimer’s Society told us: “There are 700,000 people with dementia in the UK and this is forecast to increase to 940,110 by 2021

69 Q 159

70 Q 160

71 Ev 6, 42

72 Q 724

and 1,735,087 by 2051.”⁷³ However, here too there seem to be grounds for optimism as regards managing the condition in future. We heard from the Society’s Head of Policy and Public Affairs, Andrew Chidgey, that :

When you talk to the dementia research community, what they will say is there is not likely to be a cure on the horizon in the next 15 years; however, what they do say is that they are quietly confident that we may see some disease modifying treatments, so that is to say although people may continue to develop diseases in the brain that cause dementia, we may be able to significantly modify the progression of the disease which will mean we may be able to keep people earlier in the condition with less significant symptoms than we are at the moment [...] If we can delay the onset of progression of dementia, then I think that is probably where the most significant opportunity lies.⁷⁴

Future availability of support from carers

58. As we have already noted, the greater part of care and support is provided by carers, such as spouses, partners, family members, friends and neighbours. Consequently, it can be expected that the extent of future demand for formal care services will be substantially determined by the availability of this informal care and support. According to the National Statistician:

The rising numbers of older single people and the break-up of families through divorce are likely to reduce the provision of informal caring. In addition, children caring for their parents will be increasingly old themselves and potentially caring for their children or grandchildren at the same time as their ageing parents.⁷⁵

59. We received evidence on this from Linda Pickard, a Research Fellow at the Personal Social Services Research Unit (PSSRU), drawing on work undertaken for the Cabinet Office and the DH, according to which:

The evidence suggests that around 250,000 disabled older people could be left without family care by 2041, opening up an unpaid ‘care gap’ and potentially increasing demand for social care services.

60. Ms Pickard concludes that, based on the demographic and other assumptions used in the PSSRU model:

73 Ev 57. The source for these figures is the 2007 *Dementia UK* report, commissioned by the Alzheimer’s Society and prepared by the London School of Economics and the Institute of Psychiatry at King’s College, London; the study estimated that 574,717 people in England (84% of the UK total) currently have dementia (as at 2005). The anticipated figures for 2021 and 2051 are arrived at by applying to population projections the observed rate of prevalence of dementia (a fifth of people aged between 85 and 89 have dementia; over the age of 90 the rate approaches a third). They are, thus, projections rather than forecasts. A recently published study by the Oxford University Health Economics Research Centre, *Dementia 2010* (commissioned by the Alzheimer’s Research Trust), estimates that there are currently 821,884 people with dementia in the UK (news.bbc.co.uk/1/hi/health/8493248.stm).

74 Q 618

75 Karen Dunnell, “Ageing and Mortality in the UK: National Statistician’s Annual Article on the Population”, *Population Trends* 134 (2008), p 22

On the demand side, currently around 600,000 disabled older people receive informal care from adult children and this is projected to rise by 90% to 1.3 million in 2041 [...] On the supply side, there are currently 400,000 people providing intense informal care to parents and this is projected to rise by 27.5% to 500,000 in 2041 [...] Therefore, the care-receivers: care-providers ratio is projected to fall from 0.6 in 2005 to 0.4 in 2041.⁷⁶

61. However, predicting the future availability of such care is complex and speculative. Mr Wittenberg commented on some of the variables involved in making such forecasts:

[Ms Pickard's] base case assumption really is that the propensity to provide informal care is constant, that is to say that if a given age, gender, educational attainment level X% provide informal care to their parents, then one way of looking at it is to say "Let's assume X% remains constant over time". Of course it may not do. So there are ways of looking at building up scenarios in some of these issues but of course the future is uncertain and with informal care not being able to depend on employment-related issues and geography, where people live, which in turn may be related to employment, makes it a very difficult area.⁷⁷

Future unit costs of care

62. In addition to rising demand associated with demographic pressures, another significant factor in the future cost of social care could be the unit costs of providing it. In this case too, the modelling work done for the DH entails making a projection based on certain assumptions, as Mr Wittenberg explained to us:

the Treasury have assumed that productivity and average earnings will both rise by 2% a year in real terms. This is for very long-term projections over the next 50 years and we have taken that as our base case. Of course that may not be the case and there are lots of reasons why it may not be. Particularly if one uses the 2% assumption and particularly assuming that the average earnings of care staff will go up in line with the average earnings of the labour force generally, that may not be the case [...] There are also issues about expectations. Obviously if quality of care rises, that may or may not affect the unit costs.⁷⁸

Future expectations

63. The DH recognises that the "baby boomers" have grown up with much greater expectations of life than their parents' generation; and that rising expectations will continue to characterise future cohorts. It is anticipated that older people will, therefore, be increasingly demanding customers of social care services, expecting high quality, as well as choice and autonomy. The Green Paper quotes the Chairman of the Audit Commission as saying: "Ex-punk rockers and Rolling Stones fans are not going to be happy with a cup of

76 Ev 44

77 Q 173

78 Q 184; cf. Q 541

tea and daytime TV”.⁷⁹ The Department links the issue of rising expectations closely to the need to personalise social care, which we discuss further in subsequent chapters of our report.

64. Although much is made of changing expectations of care, there seems to be no solid quantitative evidence in this regard. Mr Wittenberg told us:

the expectations around the quality and types of care and the quantity of care is another big issue, that is clearly a speculative one. There is a view that expectations of future cohorts may be higher but I am not aware of one particular measurement of that.⁸⁰

Future availability of funding

65. The ability of the social care system to meet future levels of demand will be substantially determined by the future “funding envelope”, i.e. the amount of money, from all sources, that is spent on it, and how sustainable those sources of funding are. This depends on the future availability of money from private sources (income and savings) and from the public purse, and the funding system that is used.

66. In 2008 the Government stated that by 2026 a £6 billion “funding gap” would have opened up in social care if the system did not change in response to new pressures (i.e. this would be the additional cost just of standing still).⁸¹ The recent Green Paper, however, does not quantify this gap; nor does it consider the expenditure needed to ensure that in the future there is less unmet need than under the present system. The Green Paper does, though, consider the issue of possible funding models. We discuss these issues further in later chapters of this report.

The funnel of doubt

67. As is apparent from our evidence, there is a large element of uncertainty involved in projections of future social care demand and costs. Mr Wittenberg told us:

some of these factors are difficult to look at and it means there is a range of uncertainty around the estimates. You remember that the Royal Commission talked about a funnel of doubt and had a diagram opening up a wedge of different projections;⁸² that was a very good phrase in a sense to have used.⁸³

79 Department of Health, *Shaping the Future of Care Together*, Cm 7673, 2009, p 53

80 Q 172

81 This figure represents the difference between the cost of providing social care in 2026, allowing for increased demand and increased unit costs, and current expenditure levels, uprated to allow for 2% annual real terms increases, in line with anticipated GDP growth (Department of Health, “Technical note: The £6 billion funding gap for adult social care”, 2008).

82 Royal Commission on Long-Term Care, *With Respect to Old Age*, 1999, para 2.14; Research Volume 1, Figure 5.1, p 39

83 Q 173

Our predecessor committee in 1996 also heard about “an ‘expanding funnel of doubt’ when projecting so far into the future”.⁸⁴

68. As Mr Wittenberg explained, there is no statistically meaningful margin of error in making such long-term projections; there is only a “plausible range”⁸⁵ for each component. Even small divergences from the assumptions made can cause big differences in actual outcomes in the long run, since the impact of any change is compounded over time. This means that the uncertainty becomes progressively greater the further in the future that a projection applies, hence the widening of the “funnel doubt” around projections.

Conclusions

69. **A compelling argument for thoroughly reforming the social care system is that in its current form it will struggle to meet people’s needs under the pressure of future growth in demand and costs. However, we recognise that anticipating these is a far from exact science and there is much uncertainty. Projections are made from observed trends, based on a series of plausible assumptions about a number of variables, but within a considerable “funnel of doubt”, which expands into the future.**

70. **In order to minimise that doubt, the best possible evidence base is needed. We are, therefore, extremely disappointed that, fourteen years after our predecessor committee called on the then Government to commission better data on healthy life expectancy, the delay in doing so means the available data are still inconclusive. The Cognitive Function and Ageing Study and the English Longitudinal Study of Ageing are expected in due course to yield cohort data and we recommend that the DH take full account of these as soon as they become available.**

71. **Despite the degree of uncertainty about future demand and cost, it is nonetheless clear that, on all reasonable assumptions, the social care system will face considerable increased pressures in the decades to come. It is important, though, to avoid demographic despair and alarmism. Population ageing is far from being a new phenomenon, nor is it unique to this country. Its effects have not yet proved catastrophic and there is no compelling reason to suppose that they will in the future, provided the right political decisions are made now.**

72. **We note that, in its presentation of the data on life expectancy, the DH has confused period and cohort measures of life expectancy, as well as life expectancy at birth and at age 65. In so doing, there is a danger of overstating the extent of demographic change and potentially discrediting the projections used. In an area that is characterised by uncertainty, it is essential that care is taken to interpret existing data accurately.**

73. **The Department has also not made clear that part of the demographic challenge facing the social care system is the transient “cohort effect” of the ageing of the population “bulge” born during the post-war “baby boom”. The fact that the first “baby boomers” will not enter their mid-80s until the early 2030s means that there is still a 20-year “window of opportunity” in which to prepare for this. This is not an**

84 Health Committee, Third Report of Session 1995–96, *Long-term care: Future provision and funding*, HC 59–1, para 98

85 Q 182

argument for complacency, far from it; but there is a chance to address the challenge systematically so as to ensure comprehensive and lasting reform, rather than being led by panic into further incremental reform of marginal and temporary value.

74. We are concerned that an ageing population is too often seen in public debate as something negative, a problem to be solved, with older people regarded as a burden. The fact that many more people can expect to live well into old age is one of society's greatest achievements and something to be celebrated rather than lamented.

75. Longer life expectancy does not inevitably mean more years lived with ill health and disability; people can live lives that are healthier as well as longer, and many older people are living proof of this. Future healthy life expectancy is not fixed; actions taken now could help to make the "compression of morbidity" more likely. The importance of research to develop curative or mitigating interventions for long-term conditions should not be underestimated. Such research could pay major dividends, in terms of health outcomes and public spending, as well as in individuals' quality of life, and must be adequately supported and funded. Similarly, the importance of public health interventions must be acknowledged. The health risks posed by smoking, drinking, poor diet and lack of exercise have important implications for future social care demand. This reinforces the need for interventions to address these issues, although their effectiveness must be rigorously evaluated. It also reinforces the importance of coordinating health and social care services.

76. We would also counsel against pessimism regarding the affordability of care and support in the future. The old-age "support ratio" or "dependency ratio" is not the most important factor to take account of in determining the likely future affordability of social care. Our society must not underestimate its ability to become more productive and wealthier, nor indeed the contribution that the growing numbers of older people will continue to make to that.

77. While these challenges to the social care system lie in the future, there is evidence that at present the system too often fails to provide adequate support to people in need, as we explore in the next chapter.

4 Shortcomings of the present social care system

78. In the course of our inquiry it became evident that the current social care system is no longer fit for purpose. In this chapter we examine the multiple shortcomings which any reform must address. These failings can be found at all stages of the journey that a person might make in using social care; in particular, they relate to:

- lack of information and advice;
- lack of joined-up care;
- limitations and variations in access to services;
- unfairness of means-testing and charging;
- significant demands on carers;
- lack of focus on prevention, rehabilitation and reablement;
- high levels of unmet need;
- variations in quality of care;
- age discrimination.

Lack of information and advice

79. An important precondition of being able to access care and support is having clear information and advice about what services are actually available (both from the local council and from alternative sources) and how to go about obtaining them. Providing good information is particularly critical because of the difficult and rushed circumstances in which social care decisions are often made.

80. The LGA told us about the scale of councils' efforts to fulfil their obligations in this regard:

Despite [financial] pressure, councils are spending, on average, £1.98 million—or £294.2 million in total—(2007–08) on adult social care that people can access when they need it and without a formal assessment, such as information and advice services.⁸⁶

81. However, the availability of such services is clearly very variable. The Parkinson's Disease Society (PDS) told us about:

poor information provision and signposting to services, especially with regard to signposting to social care support [...] over half (52%) of carers [in a survey]

identified “getting expert advice on health and social services”; as “very important”, but only a fifth (20%) were actually receiving this, and only a third of carers were aware of their right to a carers’ assessment.⁸⁷

Similarly, we heard from Mencap, the learning disability charity, that:

one of the greatest barriers to social care is the lack of information and support to the individual and the family. This includes a failure to provide accessible advice and information and often a complete failure to provide any information and support.⁸⁸

Lack of joined-up care

82. The social care system has a complex and difficult interface with other forms of state care and support:

- Non-means tested, non-contributory cash benefits for disabled people and carers are provided by the Department for Work and Pensions (DWP).
- Housing support services are administered locally by councils⁸⁹ (with supported/sheltered housing the joint responsibility of housing and social care services). These services are now substantially provided through Registered Social Landlords in the independent sector.
- Free health care is provided by the NHS, whose relationship with the social care system is of fundamental importance but has long been recognised as especially problematic.

In 1998 our predecessor committee identified multiple barriers to the two systems working together;⁹⁰ some of these problems have been mitigated but none of them has been eliminated.

Differences in assessment processes, eligibility criteria and means-testing arrangements between these forms of care and support result in a system that is confused and highly complex, with people too often receiving disjointed and ill-coordinated support.

87 Ev 56

88 Ev 8

89 Housing support services are provided by the authorities that also have social services responsibilities, except where there is two-tier local government, in which case responsibility rests with borough/district councils.

90 Health Committee, First Report of Session 1998–99, *The Relationship between Health and Social Services*, HC 74–I. The barriers identified were:

- Lack of Clarity of Role and Responsibilities;
- Financial Barriers;
- Different Charging Policies;
- Legal Barriers;
- Different Priorities;
- Lack of Coterminosity (of administrative boundaries);
- Different Cultures; and
- Differences in Democratic Accountability.

Cf. Health Committee, First Report of Session 1995–96, *Long-Term Care: NHS Responsibilities for Meeting Continuing Healthcare Needs*, HC 19–I; Health Committee, Sixth Report of Session 2004–2005, *NHS Continuing Care*, HC 399–I.

83. The Alzheimer’s Society reported that people with dementia and their carers “can experience great frustration and poor quality services where joined up working is not as effective as it should be”.⁹¹ Macmillan Cancer Support told us that cancer patients were too often not even assessed for social care needs “as a result of little or no joined up working”.⁹²

84. We heard from Home Group Limited, a provider of supported housing services, that:

Many clients with multiple and complex needs and/or dual diagnosis (eg mental health issues and substance misuse) are still subject to funding battles between health and social care services and frequently end up “falling between two stools” with their needs unmet until such disputes are resolved.⁹³

The mental health charity Mind also reported that people with complex needs were ill-served because “Mental health problems do not fit neatly into ‘health’ and ‘social care’ issues” and the two were poorly coordinated.⁹⁴

Limitations and variations in access to services

85. Rationing by eligibility criteria excludes many people from access to services. In 2008, the annual report on *The State of Social Care* by the then regulator for social care, the Commission for Social Care Inspection (CSCI), highlighted the situation of people “lost to the system” when they failed to meet local eligibility criteria for social care.⁹⁵ The report expressed concern that FACS was being used crudely to curb demand, with damaging consequences for vulnerable people.⁹⁶

86. CSCI was subsequently commissioned by the Government to undertake a full review of eligibility criteria for social care, and the resulting report, *Cutting the Cake Fairly*, was published in October 2008. CSCI found that some three-quarters of councils were not providing access to services for people with Low or Moderate needs.⁹⁷ (The Secretary of State for Health, Rt Hon Andy Burnham MP, acknowledged in evidence to us that he had been advised that “only one council in the country provided support in all care categories”).⁹⁸

87. The CSCI review identified multiple problems with the current system of eligibility including:

- lack of clarity and transparency;
- lack of fairness;

91 Ev 60

92 Ev 111

93 Ev 31

94 Ev 75

95 Commission for Social Care Inspection, *The State of Social Care in England 2006–07*, January 2008

96 Melanie Henwood and Bob Hudson, “Lost to the System? The impact of Fair Access to Care: A report commissioned by the Commission for Social Care Inspection for the production of *The State of Social Care in England 2006-07*”, January 2008

97 This figure is derived from CSCI Self-Assessment Survey returns from local authorities.

98 Q 877

- service-led rather than needs-led approaches;
- limitations of a risk/needs based model;
- insularity and fragmentation;
- marginalisation of prevention and inclusion agendas;
- inadequate approaches to diversion and signposting; and
- tensions between FACS and the personalisation of care and support.

88. Although FACS was intended to address concerns about a “postcode lottery” in the assessment of eligible needs, it has clearly failed to do so. Variations in eligibility thresholds can make it very difficult for people with social care needs to move from one part of the country to another, since in doing so they may lose their entitlement to care and support. The same applies to the fact that assessments are not “portable” between local-authority areas, meaning that a person can receive different assessments of need from different councils.⁹⁹

89. We received evidence that eligibility criteria pose a particular problem for people with fluctuating conditions. For example, people who have the relapsing/remitting form of MS often find that they do not meet eligibility criteria if the assessment is undertaken as a “snapshot” rather than taking account of their needs over a period of time.¹⁰⁰

90. We also heard that “resource allocations” (i.e. the sums of money available to meet each person’s needs) are often low and vary excessively by area, relative to unit costs, leading to variations in service levels. This too can make it difficult for people to move to a different part of the country. Where resource allocations are low, care and support can be limited to personal care, excluding help with other activities of daily living (such as shopping, cooking and cleaning). Where support is being provided through Direct Payments, people can find they need to “top up” with their own money in order to meet their needs properly.¹⁰¹

Unfairness of means-testing and charging

91. In Chapter 2 we outlined the current systems of means-testing and charging for residential and non-residential social care. Below we look at how these can be unfair and inconsistent in their impact on people with care and support needs.

Residential care

92. The vast majority of property owners will have assets in excess of the upper capital limit for the residential care means test (as we have noted, this is updated annually and in 2009–10 is set at £23,000). When the statutory means-testing rules for residential care were originally established, in 1948, relatively few older people owned significant assets, including property, but this is certainly not the case now. In consequence, means-testing

99 Ev 9, 11; Q 15

100 Ev 129. This issue was acknowledged by CSCI in its review of eligibility criteria.

101 Ev 55

now affects many more people than it once did. In future, many more older people will potentially be affected by means-testing, due to the ageing of large population cohorts (the “baby boomers”) with even higher levels of owner-occupation than there are among older people at present.

93. The way that the means test operates means that there is a “cliff edge” effect. Anybody with assets valued at more than £23,000 (in 2009 –10) finds that if they need residential care they receive no help at all from the state and they could be faced with unlimited, potentially catastrophic, costs. The Green Paper points out that 20% of people with care and support needs over the age of 65 will require care costing more than £50,000, whilst:

An average stay in a care home is about two years, and this can cost over £25,000 just for the cost of care; accommodation can cost as much again. But someone with a long-term condition such as Alzheimer’s disease could need several years of residential care and so could face far higher costs than this. Just four years of care and accommodation in a care home could cost over £100,000, and some people need residential care for more than ten years.¹⁰²

According to evidence that we received from Partnership Life Assurance Ltd (citing research by Laing & Buisson):

with the estimated average stay in a care home at around four years and with the average annual fees for residential care for 2009–10 being £24,908 increasing to £34,788 if nursing care is required, this could mean an average cost of £139,152. It should also be noted that one in ten people in care will live for eight years. Inevitably the cost of care is not static. This year’s figures have increased by 5.1% and 3.3% respectively from last year. Many care homes can cost more than £50,000 per year.¹⁰³

94. The fact that the relative value of property has risen considerably, particularly in the past decade or so, means that people are expected to pay much greater sums than in the past as a result of means-testing. According to the house price index published by the Department for Communities and Local Government, “Between 1997 and the peak in the summer of 2007 average UK house prices rose three-fold from £74,200 to £219,256”.¹⁰⁴ Since then, prices have fallen; but the average price in the third quarter of 2009 still stood at £197,277.¹⁰⁵ According to the insurance firm Partnership Life Assurance Company Ltd, the average amount of equity in property held at the age of 85 is £190,000.¹⁰⁶ The effect is all the more acute in London and the South East, where house prices, and care home fees, are the highest.

95. It is unlikely that many people will have to spend the entire value of their assets on residential care (given the average length of stay in a care home and the level of property

102 Department of Health, *Shaping the Future of Care Together*, Cm 7673, 2009, pp 97–98; cf. Q 22

103 Ev 98

104 Graeme Chamberlin, “The housing market and household balance sheets”, *Economic & Labour Market Review*, Vol 3 (2009), p 24

105 Department for Communities and Local Government Live Tables, Table 508 Housing market: mix-adjusted house prices, by new/other dwellings, type of buyer and region, United Kingdom, from Quarter 2 1992

106 “How will you pay for your long-term care?”, *Sunday Times*, 7 February 2010

prices).¹⁰⁷ However, large numbers of people face the prospect of having to sell their home (or to undertake private equity release or council deferred payment arrangements, which would mean their property being sold after their death),¹⁰⁸ to raise the substantial funds needed to pay for care. Their prospective inheritors, meanwhile, stand to lose a significant part of their inheritance. This situation has long been resented, for several reasons.

96. Many people mistakenly believe that social care is available free, on the same basis as the NHS, and are angered to find, when they actually have to deal with the social care system, that it is not.¹⁰⁹ The complete lack of help for people with relatively modest savings or property assets is seen as punishing the thrifty and prudent, while the feckless and improvident are rewarded. The latter point may well be unfair,¹¹⁰ but the prevalence of this view illustrates how the lack of universality in service provision can undermine social solidarity. People are likely to resent paying through their taxes for a service they themselves are not able to use and to stigmatise those who are eligible.

97. Most people expect to be able to leave their assets to their children or other inheritors and find it unjust if their ability to do so is restricted. It could be argued that property values nowadays substantially represent “windfall” gains (made partly at the expense of younger people without property assets), and that inheritance too is a form of lottery. However, another lottery (in care costs) is clearly not a fair mechanism for redistributing good fortune: the lack of “risk pooling” leads to significant “intragenerational inequity”, since older people with assets who are fortunate enough not to need residential care do not stand to lose anything.

98. There are other forms of unfairness in the system too. Because the statutory means test sets cash thresholds that are uniform across the whole country, it does not take account of local variations in asset wealth (caused by local variations in property prices). Likewise, the statutory rules on charging for residential care do not take account of local variations in the cost of providing care, the amounts different councils are prepared to pay or the expensiveness of the care provided in each individual case. This means that the proportion of the cost of providing residential care that is recouped in charges can vary between areas. While across England 29.6% of gross expenditure on residential care for older people was recouped in charges in 2007–08, it was as high as nearly 50% in some areas and as low as under 10% in others.¹¹¹

107 Q 290

108 Councils currently have the discretion, under section 55 of the Health and Social Care Act 2001, to offer a person who fails the means test on account of property assets a Deferred Payments Agreement after the end of the 12-week disregard period. Where this is approved, the council continues to pay for care, effectively providing an interest-free loan that is repaid from the proceeds when the property is eventually sold (following termination of the agreement by the resident or after their death). The council can begin charging interest on the loan 56 days after the resident’s death.

109 Q 4

110 The dissenting members of the Royal Commission on Long-Term Care argued, in support of means-testing, that “The alleged fecklessness of those who benefit under the existing system is largely urban myth. Most people are not old and poor because they have been feckless. Most people are old and poor because before that they were young and poor - low earners, unemployed, single parents, unable, even if they were willing, to save enough for their own old age” (Royal Commission on Long-Term Care, *With Respect to Old Age*, 1999, Note of Dissent, para 50).

111 HC (2009–10) 269–i, Table 38c

99. In addition to user charges, people can experience pressure to pay top-ups (paid in addition to local authority standard rates)¹¹² as a form of hidden user surcharge in order to access an appropriate or adequate quality of service or to have any choice of provider. Citizen's Advice told us:

It is unfair that [local authority] sponsored residents or their families often have to pay top up fees to obtain suitable residential care¹¹³

100. However, Sheila Scott, the Chief Executive of the National Care Association, argued that top-ups served only to buy a premium service:

Q478 Dr Taylor: [...] What is the role of these top-ups for enhanced care at the moment? How important is it for the businesses and the income?

Ms Scott: The statutory directive says that people should have choice, and the only criteria attached to that is around cost. So there will be some people who the local authority will fund, but their parent wants to go into a more expensive home and they pay the difference. That is one way. Many local authorities accept top-up, providing they can see what the extra service is. So it might be gold taps and a sea view. It might be that. It often is.

Q479 Dr Taylor: Better food; does that come into it?

Ms Scott: No, absolutely not. I think that is one of our big fears: that there would be this differential in service. Within a care home everybody would get that same service—the same food, the same service—they would be paying for some sort of extras, or the cost of the service is that much extra where it is above the local authority limit.

Q480 Dr Taylor: As opposed to a sea view, it could be a single room rather than a shared room, those sorts of things?

Ms Scott: Yes.

Non-residential care

101. Charging for non-residential care, where councils have considerable discretion, also shows great local variation and can effectively operate as a further “postcode lottery”.¹¹⁴ On average, councils recoup 11.8% of homecare expenditure in user charges. Eight authorities currently provide all homecare free of charge. At the other extreme, four recoup more than 25% of gross homecare expenditure in charges.¹¹⁵

112 Where a local authority is providing funding towards care home fees, any top-up may only be paid by a “third party”; it cannot be paid by the person receiving local authority funding. It is estimated that 28% of local authority funded residents were in receipt of third-party top-ups in 2009 (Laing & Buisson, *Care of Elderly People: UK Market Survey 2009*, p 178).

113 Ev 135; cf. Q 594

114 Coalition on Charging, *Charging into Poverty?: Charges for care services at home and the national debate on adult care reform in England* (2008)

115 HC (2009–10) 269–i, Table 38b

102. The National Pensioners Convention told us it had found in a survey significant local variations in the amount charged for an hour of domiciliary care. Over 60% of respondents were being charged between £11 and £15 per hour, more than 20% of them above this range and under 20% below it. The survey found that “in one London borough the charge for home care was £17.50 an hour, in another it was £25”.¹¹⁶ Some of this variation in charges may reflect variations in costs of providing services in different locations, but the impact on people who use services is arguably inequitable and can be a disincentive to seeking help. A survey by the Coalition on Charging in 2008 found that:

80% of the people who no longer used care services said charges played a part in the decision to end using services. A fifth (22%) of people using services suggested they would stop if charges rise.

29% of individuals did not feel their essential expenditure (related to impairment/health condition) had been taken into account in financial assessments to pay charges. Another quarter (23%) believed that only some of their essential costs were considered.

[...]

Three quarters (72%) of individual respondents and 81% of organisations said the Government should consider care service charges in care reform. 59% of individuals and 77% of organisations also believe the Government should consider ending charges.¹¹⁷

103. The current system can have a particularly deleterious impact on working-age adults with care and support needs, leading them to find themselves in a “poverty trap”. Under the means test they tend to receive their care free of charge, on the basis of having no (or a low) income and no significant assets. Fear of losing this free care can prevent them from accruing savings and discourage their families from leaving them any inheritance.¹¹⁸

Significant demands on carers

104. As noted above, since 1948 there has been no legal presumption of a duty on anyone to provide unpaid, voluntary care for family members. Where people are acting as carers, however, their experience of support from local authorities is often poor. In practice, where care is available from family members and others the amount of formal care provided is likely to be significantly lower than it would otherwise be. Raphael Wittenberg, of the PSSRU, told us that data from the GHS showed this clearly:

after controlling for people’s age and disability, taking that into account, people living alone are more likely to get care than, say, a married person living with their spouse or a married couple getting help from adult children.¹¹⁹

116 Ev 64–65

117 Ev 63

118 Ev 33, 103, 144

119 Q 174. It should be noted that people receiving care and support from carers who are not receiving formal care will not always have applied for formal care. Some may not have done so, either because they do not feel the need for

105. Mr Wittenberg told us extrapolations from GHS data indicated that:

roughly 1.75 million out of two million disabled older people in private households [...] receive informal care [...] mainly from a spouse or an adult child.¹²⁰

The monetary value of care and support from carers (i.e. what it would cost for the same service to be provided by salaried careworkers at market rates) for both adults and children in England has been estimated at £70.5 billion per year.¹²¹

106. In 2001 the Census included, for the first time, a question on the provision of unpaid care. The Census returns indicated that there were nearly five million carers in England, many of them aged over 65.¹²² According to data from the GHS, “In England in 2006, about 16% of women and 8% of men aged 50–64 had looked after someone in the week previous to being interviewed [...]”¹²³

107. While family members and others would provide care for loved ones whether or not formal support was available, many carers feel that they are not being fairly supported as a result of the inadequate scope of social care. Although they wish to continue caring, many feel the care system too often expects them to do so without respite or other support.¹²⁴ Census and other data indicate that significant numbers of people are providing care for more than 50 hours each week. There are particular concerns about care provided by young carers (those aged under 18, sometimes young children) and by very old people (usually spouses).

108. Richard Humphries, Senior Fellow in Social Care at the King’s Fund, made the important point to us that presuming too much upon care by family members and others is actually not cost effective:

expectations are too heavy, too unrealistic and that leads to breakdowns in care arrangements which could be avoided. Actually it would be much better from a preventative point of view to provide good support to carers in the first place because that is the most cost-effective and appropriate way of meeting their needs.¹²⁵

109. The demands of providing care and support can have serious effects on carers (including harm to their own health, wellbeing and living standards) as well as on wider society (for instance as a result of carers not being able to maintain their employment).¹²⁶

Mr Lloyd told us:

formal care or because they have no expectation of getting it. Also, it should be remembered that living alone is here being used as a proxy for not receiving informal care; it may be that some people living alone still receive informal of one kind or another (e.g. from friends or neighbours).

120 Q 177

121 This estimate, based on work done by researchers at the University of Leeds, was published in Carers UK, *Valuing Carers – calculating the value of unpaid care* (London, 2007). The UK figure is £87.0 billion. Cf. Q 747.

122 Age Concern and Help the Aged, *Big Questions for the future of care: Our ten tests for the Government’s Green Paper on the future of care and support* (London, 2009), p 14

123 www.statistics.gov.uk/cci/nugget.asp?id=1268

124 The benefits system provides some support to carers, in the form of the Carers Allowance, but this is very limited in scope (Work and Pensions Committee, Fourth Report of Session 2007–08, *Valuing and Supporting Carers*, HC 485–I).

125 Q 229

126 Q 748

Certainly there is hard quantitative evidence that excessive informal care provision does impact negatively on people's outcomes, whether in terms of quality of life or health [...]

According to research findings:

individuals who provided more than 20 hours of care per week particularly to a partner – this is in the older population – did show a statistically significant lower quality of life than equivalent non carers.¹²⁷

Lack of focus on prevention

110. The social care system primarily deals with existing social care needs, rather than seeking to prevent needs developing in the first place. There is too little focus on rehabilitation and “reablement” (helping people who have been ill to recover as much health and independence as possible) in situations such as following discharge from hospital.¹²⁸

111. Rationing by eligibility criteria often means that the system tends to deal with higher levels of need, typically intervening in a crisis situation, but does not seek to prevent these developing from unmet lower-level needs. Sophie Corlett, of Mind, told us:

Getting into the system: it is only accessible at the point of crisis generally or when people are really very unwell. Prevention is not something that social care is really contributing to at the moment.¹²⁹

As such, the system can aptly be characterised as “penny-wise and pound-foolish”.¹³⁰

High levels of unmet need

112. Lack of information and advice on social care services, extensive rationing by eligibility criteria and high user charges all mean that many people are prevented from accessing some or all of the care and support they need. However, quantifying the scale of this unmet need is not straightforward.

113. Since there is a duty on local authorities to assess need in this way, it might be assumed that data relating to such assessments of support needs should be available. Comparing this with data on services actually provided could give some indication of unmet need. Such a measure would not, though, be comprehensive, given that not everyone with an unmet need will have sought local authority help (because they are unaware that help is available; or they do not know how to access help; or they do not believe they will be entitled to help; or they do not themselves realise they have a need). Another complicating factor would be the extent to which local authority assessments are

127 Q 232

128 Qq 131–132, 617, 721

129 Q 684

130 SC 9 (BP)

“carer blind” in their assessment of need (i.e. made without regard to the availability of carers).

114. However, even this limited means of measurement is apparently not available nationally. John Bolton, Director of Strategic Finance in Social Care at the DH, told us that not all local authorities recorded “data as to those people that they have assessed as to which [FACS] category they fitted into: critical, substantial, moderate or low”.¹³¹ We also received evidence that, in some cases, councils apply the financial means test before they have carried out any assessment of need, despite clear guidance from the DH that this should not be the case.¹³² The Secretary of State told us he thought it unacceptable for councils to turn people away without recording their needs and argued that local authorities had a duty “to ensure that an overview is taken of levels of unmet need in the community”.¹³³

115. On the basis of this lack of data, Mr Bolton told us that nothing was known about the extent of unmet need:

Q34 Dr Stoate: [...] Do we have any idea of the levels of unmet need?

Mr Bolton: No.

Q35 Dr Stoate: None at all?

Mr Bolton: No.

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

Mr Bolton: No-one collects that data.

116. Mr Behan observed that CSCI had tried to quantify unmet need.¹³⁴ The Commission provided the following estimates in *The State of Social Care in England, 2006–7*:

— the total number of older people who receive no services and have no informal care, despite having high support needs, is around 6,000; and 275,000 older people with less intensive needs

— in the current system, 1.5 million people (60% of the total number of older people with any disability or impairment) have some shortfall in their care if it is assumed they do not have any informal care; this goes down to 450,000 people if we assume the support of family carers

— if we focus only on older people with high needs, and who receive family carer support, 50,000 people out of 850,000 have some shortfall in their care.¹³⁵

131 Q 51. CSCI found that “Councils do not monitor what happens to people signposted to other support, so unmet need is not being recorded nor are those people’s outcomes known” (Commission for Social Care Inspection, *Cutting the Cake Fairly: CSCI review of eligibility criteria for social care*, October 2008, para 3.39).

132 Ev 117

133 Q 882

134 Q 41; cf. Q 595

135 Commission for Social Care Inspection, *The State of Social Care in England 2006–07*, January 2008, p 109

However, Mr Behan also told us that there were no reliable data, as “there has been no research on unmet need which has been verified, no randomised controlled trials”.¹³⁶

117. The Secretary of State did, though, quote to us with some confidence further estimates of unmet need:

We do have an idea. I think the up-to-date figure is that there are about 300,000 people with substantial needs.

He said that, if the social care system were not reformed, “The estimate is that the number of people with unmet needs will go up to 400,000”.¹³⁷ These figures have been calculated for the DH by the PSSRU.¹³⁸ They assume a benchmark level of support equivalent to the average packages of care currently provided. This means that only people with need levels that would entitle them to state support in the present system are assumed to have needs and thus potential “unmet” needs. The figures are calculated on a “carer sighted” basis, so they only count need as unmet if it is not being met by either formal or care and support from carers. The projected rise in the level of unmet need is due to demographic factors (a projected increase in the number of older people), as well as the fact that in future greater numbers of older people will be excluded from state support by means-testing due to property ownership.

118. On the question of unmet need where carers are involved, Imelda Redmond, the Chief Executive of Carers UK, explained that there were clearly many cases where carers were receiving no support from social care services:

We know the number of people who are providing care, family carers. We know that there are 2.5 million doing 20 hours a week or more, and we know that there are between 1.7 million and 2 million people receiving social services support across all age groups. You can see a gap there and some of those will be counted in that other number, because they are getting some support, so there is quite a bit gap there.¹³⁹

Variations in quality of care

119. We received evidence that the quality of care and support can be poor. Below we look at evidence of poor quality care, the regulator’s view of standards and possible reasons for poor quality.

136 Q 41

137 Qq 880, 882

138 Julien Forder and José-Luis Fernández, *Analysing the costs and benefits of social care funding arrangements in England: technical report*, Personal Social Services Research Unit Discussion Paper 2644, July 2009, Table 25, p 39

139 Q 686

Poor quality care: the evidence

Shortcomings in homecare

120. Several witnesses highlighted the problems created by the apparently widespread practice of commissioning homecare visits lasting just 15 minutes, seemingly as an economy measure. Mr Nixon, from the MS Society, told us:

Fifteen minutes is fine for a non-disabled person to wash their hands and face and get themselves sorted out, but the issues are that when you then have someone with a disability who has a complex set of needs, they might need to move slowly, they might need to be encouraged and supported during what they are doing, 15 minutes is a nonsense. It is a 45-minute issue to get somebody out of bed and get somebody sorted out in the morning.¹⁴⁰

121. Another aspect of homecare that causes difficulty is high turnover of staff, with around a fifth or a quarter of the workforce leaving each year. This, along with use of multiple providers, can undermine continuity of care, compromising quality. High turnover tends to mean that staff are too often untrained; and such training as homecare workers do receive is usually just “on-the-job training”.¹⁴¹

122. Inflexibility and lack of personalisation can be the most frustrating aspects of homecare for people who use services, for instance having no choice over what time they get up or go to bed. One memorandum of evidence we received mentioned the possibility that a care worker might be “putting [a client] to bed at five in the afternoon”;¹⁴² a witness told us about people “being expected to go to bed at 6.00 in the evening or get up at 10.00 in the morning”.¹⁴³ Considerable logistical difficulties can confront homecare agencies in trying to organise staff rotas, which results in people being visited at unacceptable hours. The desire for flexibility in this is often identified as a reason for employing a PA rather than using standard services. A survey in 2008 found that “A third (34%) of individuals described having no choice over the support services they used.”¹⁴⁴

Shortcomings in residential care

123. Lack of choice and insufficient personalisation are also problems in residential care, as we heard from Stephen Burke, the Chief Executive of the older people’s care-advice charity Counsel and Care:

140 Q 705. Cf. Qq 598, 702, 721, 767; Ev 35, 54, 82

141 Qq 357, 360, 380, 408, 415, 498, 513, 598; Ev 51, 52, 53, 82, 83, 109

142 Ev 32

143 Q 598

144 Coalition on Charging, *Charging into Poverty?: Charges for care services at home and the national debate on adult care reform in England* (2008)

simply again not enough notice is taken of residents' wishes, in terms of their choice of activity, timing of when they eat, and so on, let alone respect of their own culture and food and things like that.¹⁴⁵

124. There are particular concerns about the quality of residential care for people with dementia. A steady stream of disconcerting anecdotal evidence seems to indicate that, too often, while people's physical needs are catered for, their specific needs arising from their dementia can be poorly addressed.¹⁴⁶ While we were conducting our inquiry, disturbing allegations of overmedication and inappropriate use of tube feeding of people with dementia in care homes were published.¹⁴⁷

125. Yet there is a wealth of evidence to show that the quality of life for people with dementia can be greatly enhanced by treating them in a person-centred way, according them dignity and respect, regardless of their level of disability or dependence. Symptoms of dementia can be accommodated, whilst providing an environment and experiences that are stimulating and life-enhancing, and allowing opportunities for autonomy, independence and interaction with other people.

The regulator's view of care standards

126. The quality of social care has been regulated, in various ways, for some time; and the scope of regulation has increased significantly in recent years. Below we examine what evidence from the regulators reveals about the quality of care.

Regulation of adult social services departments

127. Annual quality ratings for local authority social services departments have been published since 2002, with responsibility for them passing to CSCI's successor, the Care Quality Commission (CQC), in 2009. Ratings on current performance now use grades of "Performing excellently", "well", "adequately" or "poorly", in respect of each of seven outcomes¹⁴⁸ and of "Delivering outcomes" overall.

145 Q 598

146 Recent examples include the television series "Can Gerry Robinson Fix Dementia Care Homes?" (broadcast on BBC2 on 8 and 15 December 2009) and the book *Beyond the Façade* (Brentwood, 2008), by the whistleblower Eileen Chubb, of the group "Compassion in Care" (www.compassionincare.com).

147 Professor Sube Banerjee, "The use of antipsychotic medication for people with dementia: Time for action – A report for the Minister of State for Care Services", November 2009; "'Chemical cosh' drugs 'killing thousands a year'", *Daily Telegraph*, 13 November 2009; Royal College of Physicians /British Society of Gastroenterology, "Oral feeding difficulties and dilemmas: A guide to practical care, particularly towards the end of life", January 2010; "Care homes forcing elderly to have feeding tubes fitted", *Guardian*, 6 January 2010

148 The seven outcomes are:

- Improving health & well-being;
- Improved quality of life;
- Making a positive contribution;
- Increasing choice & control;
- Freedom from discrimination and harassment;
- Achieving economic well-being; and
- Maintaining dignity & respect.

128. In December 2009, CQC published its assessment of the performance of 148 local authorities for the year to March 2009, along with an analysis of commissioning. The Commission reported that:

nearly a quarter of councils need to improve significantly in personalising care, to give people who use services more choice and control over their care. And about a third of councils should be doing a lot more to give people greater dignity and respect—including improving arrangements for safeguarding people [i.e. protecting vulnerable adults from potential abuse].¹⁴⁹

However, the ratings show overall improvement on the previous year, as the ratings have shown every year since their inception. The President of the Association of Directors of Adult Social Services (ADASS), Jenny Owen, told us, on a day when the publication of the latest CQC ratings had attracted adverse media coverage:¹⁵⁰

There are now no poor councils for the first time ever¹⁵¹ and 95% of good councils [i.e. performing “well” or “excellently”]. That should have been the headline but it was not. There are eight adequate councils. I would be very worried about that performance. There would have been some very significant work going on between the Care Quality Commission and those local authorities from the time that they were assessed in that way, which was back in the summer [...]¹⁵²

Councillor Sir Jeremy Beecham, Vice-Chairman of the LGA, likewise said: “The poor are no longer with us, so to speak. I think Jenny said to me before, ‘Adequate is the new poor.’”¹⁵³

129. When we asked Baroness Young, the then Chairman of the CQC, about the reliability of the regulator’s ratings of local authorities she told us:

I think we have an effective process of working with councils to identify the ones who are not commissioning as well as they should [...] We meet with them on a regular basis, we develop joint action plans with them, we monitor whether they are achieving those action plans [...]¹⁵⁴

149 Care Quality Commission, *Performance judgements for adult social services An overview of the performance of councils in England*, December 2009, p 1. Two councils were rated “Poor” on Outcome 7, “Maintaining dignity & respect”.

150 “Thousands condemned to live in squalid care homes”, *The Times*, 3 December 2009; “Nearly 4,000 adult social services criticised over level of care provided”, *Guardian*, 3 December 2009; “Care for 80,000 elderly not up to standard”, *Daily Telegraph*, 3 December 2009; “Adult social care warning for eight areas of England”, *BBC News Online*, 3 December 2009, news.bbc.co.uk

151 In fact, no council has ever been rated “Poor” on “Delivering outcomes” (under the 2007, 2008 and 2009 ratings system) or “No” on “Serving people” (the equivalent in the 2005 and 2006 ratings system).

152 Q 837

153 Q 836

154 Q 306

Regulation of providers

130. The publication of quality ratings for social care service providers (both in-house services and independent sector contractors), based on inspections, was begun in May 2008. CQC also took on responsibility for these when it replaced CSCI in 2009.¹⁵⁵

131. When we heard from the then Chairman of the CQC, Baroness Young, she told us that “about 3,700 services”—the correct figure is actually 4,499 (18.4% of the total)—fell into the “poor” and “adequate” categories in the latest ratings:

that is not acceptable, so there needs to be action on these poor providers to get them further up the quality spectrum.

However, she emphasised that:

Generally speaking, performance has been improving for particularly residential care services over the last few years and performance against the national minimum standards has risen [...] for six years in a row.¹⁵⁶

132. Ms Owen told us that providers’ poor performance can be down to temporary fluctuations in standards. In such circumstances the solution is not simply for local authorities to stop commissioning services and remove residents. It would be completely inappropriate to disrupt the lives of residents by doing this instead of working with providers to “try to drive up [their] standards”.¹⁵⁷

133. When we asked Baroness Young about the danger of regulation being merely a “tick box” exercise, she told us:

I have been very impressed [...] with the quality of the inspection of services, but, as you know, we have got a new registration system coming in and we are particularly keen to build on the expertise that has been developed over time in inspecting services to make sure that the inspection process is as effective as possible and focuses on the things that people really care about—the outcomes, whether they are treated with dignity and respect, whether their rights are respected, as well as a whole variety of other issues—and we want to very much focus on whether the care that people get is what they should have the right to expect, in terms of what it does for them, rather than simply looking at processes and policies, which can lead to a bit of a tick-box approach.

134. A new unified health and social care regulatory system is being implemented this year, with registration requirements (which are expected to replace the current National Minimum Standards for social care)¹⁵⁸ coming into force on 1 October 2010 for adult

¹⁵⁵ Regulation does not apply to services purchased from PAs, family members or friends using Direct Payments, even if those services include personal care. Day care settings that provide personal care are also unregulated.

¹⁵⁶ Q 303. The number of adult social care services rated “poor” totals 426 (1.7%) and those rated “adequate” total 4,073 (16.7%) (Care Quality Commission, *The state of health care and adult social care in England: Key themes and quality of services in 2009*, HC (2009–10) 343, p 74).

¹⁵⁷ Q 837

¹⁵⁸ Fear that many care homes would be driven out of business by the environmental standards for care homes led the Government to downgrade this aspect of the NMS to the status of “aspirational” only in 2003. According to the leading analysts of the care home industry: “This about-turn in government policy [...] has held back modernisation

social care providers.¹⁵⁹ The CQC will have new powers of enforcement and intervention, including cancellation of registration. It is also planning to introduce quality assessments that will complement its new registration process by providing independent information about the quality of care.

Possible reasons for poor quality care

135. A number of reasons for poor quality care were put to us in the course of our inquiry. Below we consider these and the evidence for them.

Business discontinuity

136. Ms Owen told us that:

One of the main reasons why homes go in and out of ratings is because they might lose their home manager or the domiciliary care manager, and the manager has a very big impact on the quality, and it can be temporary.¹⁶⁰

We heard a similar view from Baroness Young, who told us there was evidence that poor quality was often associated with “change of manager” and “change of owner”.¹⁶¹

Underfunding of providers

137. Until the 1980s, the majority of social care, both residential and domiciliary, was directly provided by local authorities themselves. Since then, however, local authorities have become, either willingly or as a result of central government policy, increasingly commissioners rather than providers of services. Services are now usually contracted out to the independent sector, made up of both voluntary sector and for-profit providers. Since the 1990s, larger for-profit providers have become prominent in parts of the residential care market, with very large corporate concerns emerging, some backed by private equity investors.

138. It is a common complaint of independent sector providers that they are underfunded by local authorities which relentlessly drive down contract values by capping prices below the cost of service provision and awarding contracts to the lowest bidder in a highly competitive market. This obviously constrains providers’ ability to provide a quality service.

139. In 2007–08, average unit costs for a place in a local authority care home were £716 per week, compared to £420 per week in an independent sector residential care home and £467 in a nursing home; there were significant variations between councils, particularly in

of the care home sector by in effect giving many physically sub-standard care homes a licence to operate indefinitely” (Laing & Buisson, *Care of Elderly People: UK Market Survey 2009*, p 43).

159 Services purchased from PAs, family members or friends using Direct Payments will continue to be unregulated under the new system, as will day care settings that provide personal care. Shared lives services (adult placements) that do not involve personal care will not need to be registered under the new system, although they are currently regulated.

160 Q 837

161 Q 306

respect of local authority care homes.¹⁶² Mr Laing told us that Laing & Buisson had calculated that “for a provincial residential home outside the London area £540 a week would be a fair fee [...] and £670 a week for a provincial nursing home”.¹⁶³

140. Average gross expenditure per hour on homecare in 2007–08 was £14.45; again, there were significant variations between councils.¹⁶⁴ Colin Angel, of the UK Homecare Association, told us:

when councils provide a homecare service they are currently doing that at a gross average hourly rate of £22.30. The same figure for the independent sector is £12.30. So we are operating, we believe, in a situation where costs are at an absolute minimum and we do not think there is much to squeeze.¹⁶⁵

141. The Association identified as a particular problem the use of “e-tendering”,¹⁶⁶ arguing that this led to “a ‘Dutch auction’ approach, where care contracts are won by the lowest bidder”, which “then impacts on pay levels and exacerbates recruitment and retention difficulties.”¹⁶⁷ Likewise, we heard from Martin Green, the Chief Executive of the English Community Care Association, that e-tendering:

has been something which we have identified as being a real problem within the sector although of course we did identify it and we got some good support from people like Baroness Young, the Chairman of the Care Quality Commission, who condemned it, and likewise some people in local authorities and in the Department of Health. It seems to me absolutely outrageous that you would set the goal of delivering high quality care, go through a tender process and then do a Dutch auction. I can understand why you might do that if you are buying a commodity like a pen for a local authority but certainly not in the arena of personalised care services.¹⁶⁸

142. Nestor Healthcare Plc-Social Care Division told us that in cases where “the contract would not be financially viable in terms of being able to deliver quality services for the price set by the local authority”, it had “withdrawn from the tendering process rather than compromising the quality of service provision”.¹⁶⁹ Similarly, we heard from a voluntary sector provider, Sue Ryder Care, that in some cases it:

has chosen to withdraw from the bidding process as the parameters within which we would have to operate under the contract would not enable us to provide a quality

162 HC (2009–10) 269–i, Tables 35a, 35b, 35c, 35d

163 Q 581

164 HC (2009–10) 269–i, Tables 35a, 35e

165 Q 439

166 “E-tendering” is the use of automated, online systems for the process of advertising contracts, gathering bids and awarding contracts. It is intended to make the process of tendering faster, easier and less costly.

167 Ev 51

168 Q 519

169 Ev 35

service. In the case of Walsall, after Sue Ryder Care removed itself from the process the next two incumbent service providers were suspended by CSCI.¹⁷⁰

143. Baroness Young told us there was evidence that “major cost reduction programmes” were associated with lapses in quality.¹⁷¹ Further evidence of underfunding is apparently provided by the need in some cases to pay top-ups to get a good standard of care, which we have already noted. The same can be said of the fact that self-funding care home residents can pay significantly more than council standard rates for an equivalent standard of care, which is often seen as evidence that self-funders are effectively subsidising council-sponsored residents.¹⁷²

Alleged profiteering

144. Considerable profits are made by corporate social-care providers. Recent financial results from the largest commercial care home operators in the UK show annual rates of profit on one measure as high as 28% of turnover.¹⁷³ Representatives of the larger providers insisted that very high headline figures were too easily misunderstood because of the complexity of the businesses concerned.¹⁷⁴ William Laing, of the leading industry analysts Laing & Buisson, told us that the prevalent rates of return were what the capital markets deemed to be a “reasonable profit level” and were justified “because running a care home is a moderately risky business”.¹⁷⁵ Colin Angel, of the UK Homecare Association, emphasised that without a return on investment the private sector would not be interested in supplying services. He denied that “profit is squeezing quality down”, maintaining that “the purchaser would be far more likely to be responsible for that”.¹⁷⁶

145. However, UNISON, which represents many social care workers, insisted that there was a clear link between the profit motive and poor quality, and that “the advantages of in-house provision when it comes to reliability, accountability and quality” should be recognised.¹⁷⁷ Sampson Low, a National Policy Officer for the union, told us:

put plainly, the profits for shareholders are funds that are simply not available for care and if services are further sub-contracted, as they often are, to other providers, agencies and others, then there is a sort of second and third tier of profit margin that has to be found.¹⁷⁸

146. Mr Low denied that this claim was based on no more than UNISON’s ideological bias against the private sector and he was backed up to an extent by Baroness Young:

170 Ev 110

171 Q 306

172 Ev 135; Qq 121–123, 187, 446, 472, 477, 481, 594

173 This is calculated on an EBITDAR (Earnings Before Interest, Taxes, Depreciation, Amortization and Rent) basis (Laing & Buisson, *Care of Elderly People: UK Market Survey 2009*, p 212). We were told that a return on revenue in the “high 20s” was “more or less” equivalent to a return on capital of 12%.

174 Q 532

175 Q 587

176 Q 531

177 Ev 82

178 Q 316

Could I break the habit of a lifetime and support UNISON slightly with some figures that we have got from our inspection processes about the comparative quality between council-run services, voluntary-run services and privately run services? I do not think the gradient is huge, and this is an art rather than science, but council services have got the largest proportion of good and excellent ratings at 87%, voluntary sector services at 86% and 74% for privately run services.¹⁷⁹

147. The same type of quality gradient between for-profit and non-profit providers was found in a review of evidence from nursing homes in a number of countries outside the UK, recently published in the *British Medical Journal*. However, the authors noted that “Many factors may [...] influence this relation in the case of individual institutions”; and they identified the need for further research.¹⁸⁰

Staffing issues

148. Whether as a result of low tender prices, excessive profits or other factors, we heard that low wages, lack of training and career-development, inadequate staffing levels and high staff turnover are significant factors in undermining quality.¹⁸¹ At the root of this seem to be extremely low levels of pay, allied with very low status,¹⁸² meaning that to be a care home worker one must be either “altruistic or desperate”.¹⁸³ Data from Skills for Care¹⁸⁴ show that the median hourly pay rate for a care worker in England (at December 2008–February 2009) is £6.56 per hour. There is significant regional variation, with the rate in some regions as low as £6.00. There is also variation between care settings: in residential care homes the median hourly rate is £6.48; in nursing homes it is £6.10; and in homecare it is £6.80.¹⁸⁵ UNISON told us that where homecare workers were paid per call, rather than a straightforward hourly rate, they could earn as little as £5.40 an hour overall,¹⁸⁶ i.e. below the current (2009–10) National Minimum Wage of £5.80 per hour for workers aged 22 years and older.

149. Migrant workers are a key part of the care home workforce.¹⁸⁷ A recent Oxfam report claimed that migrant workers were being exploited by some care homes, with employers

179 Q 317

180 Vikram Comondore *et al.*, “Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis”, *British Medical Journal*, vol 339 (2009), b2732

181 Q 306

182 Qq 317, 770

183 Q 476. This comment was made by Lord Sutherland at a meeting in the Palace of Westminster on 18 November 2009 (“Shaping the Future of Care Together – Green Paper ... making the vision a reality”), organised by Public Policy Projects.

184 Skills for Care is part of Skills for Care and Development, the sector skills council for social care, children, early years and young people’s workforces in the UK. Skills for Care aims to improve adult social care services across the whole of England by supporting employers’ workforce development activity.

185 Skills for Care, National Minimum Data Set – Social Care briefing no. 8 (Pay), April 2009; *cf.* Ev 52; Qq 445, 473–474

186 Ev 82

187 SC 54

often paying less than the minimum wage;¹⁸⁸ this was, however, denied by the care home owners' representatives who gave evidence to us.¹⁸⁹

Age discrimination

150. Many of the shortcomings in social care appear to relate to inherent and pervasive ageism in the system. Mr Wittenberg told us about the work done by his PSSRU colleague Professor Julien Forder for the DH on the issue of alleged age discrimination in social care:

Analyses of two datasets, the British Household Panel Survey (BHPS) and the national evaluation of Individual Budgets (IBSEN), showed indications of differences in levels of support between age groups after accounting for differences required to compensate people with varying levels of need (e.g. disability and impairment). The IBSEN data suggests that older people who use services (65 and over) would require a 25% increase in support for these age differences compared to younger people (aged 18 to 64) to be removed. The BHPS data more tentatively suggest that older people's access to services is slightly more limited than [that of] younger people [...] The conclusion of the research that Jules Forder did was that, subject to a long list of caveats, the cost to public funds of eliminating age discrimination in adult social care by increasing the services for older people would be in the range of £2 to £3 billion per year [...]¹⁹⁰

151. We heard dismaying evidence regarding what this apparent institutional bias against older people means in practice. The evidence of Andrew Harrop, Acting Charity Director at Age Concern and Help the Aged, was particularly striking:

There is a very good case going through the courts, the McDonald case, which demonstrates this, where a service user who was 64 was assessed for a package of around £700 per week including ILF [Independent Living Fund]¹⁹¹ support; for various administrative reasons, the application fell and was remade after her 65th birthday, she was turned down for Independent Living Fund, and then the council said, "We will not give you that package we assessed you for, we will not give you attendance at night, and instead we will make you wear incontinence pads all night rather than help you go to the toilet, even though you are not incontinent". That is a shocking example of age discrimination in practice. It really shows that it is also about assumptions, the outcomes people expect for different age groups are really different [...]¹⁹²

188 Oxfam, *Who cares?: How best to protect UK care workers employed through agencies and gangmasters from exploitation*, December 2009; "Unfair demands", *Guardian*, 2 December 2009

189 Q 449–450

190 Q 209. The published study is Julien Forder, *The Costs of Addressing Age Discrimination in Social Care*, Personal Social Services Research Unit Discussion Paper 2538, April 2008.

191 ILF is a form of benefit paid by the DWP to help disabled people under the age of 65 to live more independently.

192 Q 603

152. Mr Harrop pointed out that resource allocations for Personal Budgets make this discrimination all the more transparent.¹⁹³ Ms Redmond, of Carers UK, similarly told us about:

a family where the husband was very severely disabled and his wife was doing most of his care [and] he was getting direct payments from his local authority. [...] a letter arrived from the local authority saying, “Now your husband is an older person, his hourly rate will drop from £15 an hour to £12 an hour.” That meant that she had to get rid of all those workers for the care package that she had set up, who of course were not going to work on a reduced rate, and so on.¹⁹⁴

153. The issue of age discrimination is a powerful illustration that conventional ways of organising social care are often not focused on the needs of the individual service user. In this case, unwarranted assumptions are made about individuals’ care and support needs essentially on the basis of the category of service-user into which they fall.

154. It is now illegal to discriminate on the grounds of race, gender, gender identity, disability, religion or belief, or sexual orientation in the provision of healthcare, medical treatment or social care. However, whilst it is unlawful to discriminate in employment on grounds of *age*, there is currently no statutory prohibition of age discrimination in providing health or social care.

155. The Government plans to address this anomaly by means of the Equality Bill, currently before Parliament. As part of preparing for the implementation of the Bill (which is intended to apply to health and social care by 2012), the DH commissioned a review of age discrimination in health and social care, which was published in October 2009.¹⁹⁵ The DH also commissioned the Centre for Policy on Ageing to do a UK literature review on age discrimination in social care, which was published in November 2009. A consultation about implementation of the Bill in health and social care is currently taking place.

156. We received written evidence from the Equality and Human Rights Commission assuring us that measures were being taken to address this issue without waiting for the Equality Bill to be passed.¹⁹⁶

Conclusions

157. The multiple shortcomings of the existing social care system provide powerful arguments for fundamental reform. Too often when people approach the system for help they do not receive even information and advice on what is available and how to access it. The system is also often poorly co-ordinated with other help (not least NHS services and care provided voluntarily, as well as the housing support and social security benefits systems). People who need care and support encounter various forms of rationing, including by eligibility criteria, means-testing and charging, with much local variation. Where people *are* able to access care, it can be insufficiently focused on

193 Cf. Q 783

194 Q 714

195 Q 914; Department of Health, *Shaping the Future of Care Together*, Cm 7673, 2009, p 35

196 SC 61

helping them to remain independent and avoid developing greater needs, as well as being limited in scope and not always of good quality. In these respects too, there is marked variation between local areas. The result is a social care system that:

- excludes many people with less severe care needs;
- penalises people with relatively modest financial means;
- places unfair and unreasonable demands on carers; and
- varies geographically to an extent that is strongly perceived as unfair.

In consequence of all these factors, there is a great deal of unmet need.

158. These shortcomings are all indicative of a system that: provides a residual or “safety net” service, rather than a universal one; is chronically underfunded; and is insufficiently focused on the needs and aspirations of the individual people who actually need care and support.

159. On the particular issue of quality, we note that the effectiveness of regulatory systems in uncovering and addressing poor quality care is an issue.

160. We have also concluded that more needs to be known about the role of particular factors in compromising standards. The staffing issues that we heard about (lack of training and career-development, inadequate staffing levels and high staff turnover), and their relationship to low pay levels, need to be investigated fully. The apparent quality “gradient” between for-profit and non-profit providers of care services is also of concern and this too needs to be fully examined.

161. Pervading the whole system of social care is a persistent ageism, both overt and covert. We welcome the fact that the Government and the Equality and Human Rights Commission have finally recognised this and begun to address it but we are appalled that this has taken so long.

162. The need for social care reform is clear. In the next chapter we look at how the Government has approached this and the reform programme that it has developed.

5 Plans for reform

163. There are two interrelated strands to the Government's programme for social care reform: the first is concerned with how care and support are funded, and the second with how they are commissioned and provided. In this chapter, we examine critically how these have developed, outline the vision set out in the recent Green Paper *Shaping the Future of Care Together* and look at the aspects of that vision on which there is consensus.

The road to reform

164. In this chapter we summarise briefly how the Government has approached social care reform since 1997.

Reform of funding, 1997–2008

165. In September 1997 the then Prime Minister, Rt Hon Tony Blair MP, told the Labour Party conference “I don't want [our children] brought up in a country where the only way pensioners can get long term care is by selling their home”.¹⁹⁷ Shortly thereafter, in fulfilment of a manifesto promise, the Government convened a Royal Commission to consider reform of the funding system for the long-term care of older people.

166. When the Royal Commission reported, in 1999, it recommended (although with dissent from two of its number) that all long-term personal care (including nursing care in nursing homes) should be provided free, funded from general taxation. Soon after the publication of the Royal Commission's report, our predecessor committee issued a brief report on *The Long Term Care of the Elderly*, in which it endorsed the Royal Commission's position on free, tax-funded personal care and warned “Failure by the Government to act urgently would be a serious dereliction of duty”.¹⁹⁸ The Government rejected the Royal Commission's proposal for free personal care in respect of England (in contrast, it was adopted by the devolved Scottish administration, beginning in 2002). The Government did, though, agree that nursing care in nursing homes would be made free (funded by the NHS).¹⁹⁹

167. In the years since the Royal Commission's report, the issue of social care funding reform has not gone away. On the contrary, it has become all the more pressing, for all the reasons that we have already identified. Yet, despite mounting evidence of the problems with the current system, for many years funding reform did not appear to feature on the Government's list of priorities.

168. In the absence of any Government initiative to resolve the funding issue, various bodies sought to stimulate debate. In 2006 the Joseph Rowntree Foundation (JRF)

197 Speech by Rt Hon Tony Blair MP to the Labour Party Annual Conference, 30 September 1997

198 Health Committee, Fourth Report of Session 1998–99, *The Long Term Care of the Elderly*, HC 318, para 16

199 The lack of NHS-funded nursing care in nursing homes was anomalous given that the NHS had always funded nursing care (provided by District Nurses) for people receiving care and support in their own home or in a residential care home. Since 1 October 2001 the NHS has paid for nursing care for people who fund all their care in nursing homes. Since 1 April 2003 the NHS has also paid for nursing care for residents of nursing homes who receive financial support from local authorities.

published *Paying for long-term care*, which concluded that the present system was underfunded, incoherent and unfair. The report welcomed the introduction of free personal care in Scotland and suggested immediate changes that could be made to the system in England pending fundamental reform.

169. Also in 2006, the King's Fund published a report by Sir Derek Wanless, *Securing Good Care for Older People*, which set out various funding options and indicated a preference for a "partnership" model. This would involve a guaranteed minimum level of state funding for all, expressed as a percentage of a "benchmark" good-quality package of care. The remainder of the cost would be met by user contributions, with further "match funding" from the state.

170. In December 2006 that year's Pre-Budget Report noted the "important contributions" of the Wanless and JRF reports. Proposals for funding reform would be considered "as part of the long term vision of the 2007 [Comprehensive Spending Review]", in light of whether "they are affordable [and] whether they are consistent with progressive universalism".²⁰⁰ The somewhat opaque term "progressive universalism" was defined as the principle of "providing support for all and more for those who need it most".²⁰¹ In October 2007 in that year's Pre-Budget Report the Government finally gave a commitment to the reform of social care funding, on the basis set out in 2006, promising a Green Paper on the subject,²⁰² although this was not immediately forthcoming.

Reform of delivery, 1997–2008

171. The Government proved somewhat bolder in developing a reform programme to change the delivery of care and support by means of personalisation.²⁰³

172. As we have noted, Direct Payments, the pioneering form of personalisation, were introduced in 1997. They were initially only available to eligible people aged 18–64, but this was subsequently widened to embrace other groups, including older people and carers. The power to offer Direct Payments was also strengthened and in 2003 local authorities were given a duty to offer them as an option to people who use services. Nevertheless, the take-up of Direct Payments remained very low.

173. In 2003 the "In Control" partnership, involving the Valuing People Support Team,²⁰⁴ Mencap, local authorities and a number of independent organisations, was created to develop and refine the idea of "self-directed support" and find new ways of organising

200 HM Treasury, *Pre-Budget Report, Investing in Britain's potential: Building our long-term future*, Cm 6984, December 2006, para 6.11

201 *Ibid*, para 5.55

202 HM Treasury, *Meeting the Aspirations of the British People: Pre-Budget Report and Comprehensive Spending Review*, Cm 7227, October 2007, para 6.9

203 For background information on personalisation, see Annex 2.

204 Department of Health, *Valuing People: A New Strategy for Learning Disability for the 21st Century*, Cm 5086, March 2001, sought to put services for people with a learning disability in the context of modern values and legislation conferring clear rights on all citizens, including disabled people. The Valuing People Support Team offers support and advice to people working to change services. It also promotes communication and the sharing of ideas, listens to feedback and liaises closely with the Government.

social care accordingly. In Control began as a social enterprise and subsequently became an independent charity.²⁰⁵

174. The model of “self-directed support” focused on enabling people to control the support they needed to live their life as they chose. An important means of doing this was by making available Personalised Budgets. These entailed giving each person the right to manage for themselves the budget allocated by their council to provide them with care and support (with the option of being helped to do so by others, or handing control of the budget to a third party to manage on their behalf). This budget could be (but did not need to be) taken partly or wholly in the form of a Direct Payment. Over several years, piloting of these arrangements was undertaken in a significant number of local authorities and the model of self-directed support became increasingly influential in shaping Government social care policy.²⁰⁶

175. In the meantime, the uptake of Direct Payments nationally remained very low. In 2004 CSCI attributed this to:

- lack of information for service users;
- low staff awareness of direct payments and what they are trying to achieve;
- patronising attitudes on the part of staff about the ability of people to manage a Direct Payment;
- inadequate or patchy advocacy or support services for direct payment users; and
- unnecessary and bureaucratic paperwork.²⁰⁷

176. In March 2005 the Government published a Green Paper, *Independence, Well-being and Choice*, as the basis for discussion on the future direction of social care. It envisaged social care services that “help maintain the independence of the individual by giving them greater choice and control over the way in which their needs are met”,²⁰⁸ with a focus on achieving a series of specified outcomes for people who use services. Key means of achieving this would be continued use of Direct Payments and the piloting of Individual Budgets, which would build on the model of Personalised Budgets, possibly extended to include streams of funding other than social care budgets.²⁰⁹ These pilots, which ran from November 2005 to December 2007, were evaluated by the Individual Budgets Evaluation Network (IBSEN).

177. In addition, there would be more flexible ways of assessing need and allocating funding, using as the starting point self-assessments (In Control pioneered this by means

205 Qq 733, 772–775, 781

206 www.in-control.org.uk

207 Commission for Social Care Inspection, *Direct Payments: What are the Barriers?*, August 2004

208 Department of Health, *Independence, Well-being and Choice: Our vision for the future of social care for adults in England*, Cm 6499, March 2005, p 9

209 *Ibid.*, p 11. In 2005, the Prime Minister’s Strategy Unit had advocated “individual budgets for disabled people, drawing together the services to which they are entitled and giving them greater choice over the mix of support they receive in the form of cash and/or direct provision of services” (Prime Minister’s Strategy Unit, *Improving the life chances of disabled people: Final Report*, January 2005, p 7).

of a “Resource Allocation System” questionnaire). The Green Paper did not envisage any change in the overall scale of social care funding for the next decade or more and explicitly stated that “implementing the vision will need to be managed within the existing funding envelope”.²¹⁰

178. In the January 2006 Green Paper *Our health, our care, our say* the DH said that it would extend the scope of Direct Payments and affirmed its commitment to piloting Individual Budgets, which would definitely bring together funds from a range of agencies in addition to social care funding. However, the DH explicitly ruled out “extend[ing] the principle of individual budgets and direct payments to the NHS”, on the basis that:

we believe this would compromise the founding principle of the NHS that care should be free at the point of need. Social care operates on a different basis and has always included means testing and the principles of self and co-payment for services.²¹¹

179. The 2006 Pre-Budget Report promised that “the debate around the future of social care provision” would “be informed by Individual Budgets, Partnerships for Older People Projects [POPPs],²¹² direct payments and the In Control programme”, as well as proposed changes in funding arrangements. Any changes would be judged on “whether they promote independence, dignity, well-being and control”, as well as their affordability and consonance with progressive universalism.²¹³

180. In December 2007 *Putting people first*, which was described by the Government as a unique “ministerial concordat”, was signed by six Secretaries of State as well as leading Chairs and Chief Executives across social care and local government. This set out shared aims and values to “guide the transformation of adult social care” by placing choice, independence and dignity at the heart of service delivery.

181. At the same time the DH announced that, as part of *Putting people first*, there would be a roll-out of Personal Budgets, which would take the same approach as Individual Budgets, but would apparently involve social care funding only. Coming as this did at the end of IBSEN evaluation of the Individual Budgets pilots, and before publication of the results, this announcement caused some confusion regarding DH policy.

182. A DH circular, “Transforming Adult Social Care”, published in January 2008, set out a vision for personalisation and gave details of a new ring-fenced grant of £520 million, the Social Care Reform Grant, which was allocated for the next three years to support local “transformation” (i.e. personalisation). The circular stressed the importance of working across boundaries with other services, “such as housing, benefits, leisure and transport and health”. This could be facilitated through the new Local Performance Framework, with

210 Department of Health, *Independence, Well-being and Choice*, Cm 6499, 2005, p 40

211 Department of Health, *Our health, our care, our say*, Cm 6737, 2006, para 4.39

212 POPPs were launched in 2005 to develop and evaluate services and approaches for older people aimed at promoting health, well-being and independence and preventing or delaying the need for higher intensity or institutional care. An evaluation by the PSSRU has found that “a wide range of projects resulted in improved quality of life for participants and considerable savings, as well as better local working relationships” (Personal Social Services Research Unit, *The National Evaluation of Partnerships for Older People Projects: Executive Summary*, January 2010, p 1).

213 HM Treasury, *Pre-Budget Report*, Cm 6984, 2006, para 6.11

Local Strategic Partnerships agreeing new Joint Strategic Needs Assessments to “provide the foundation for health and wellbeing outcomes within each new Local Area Agreement”.²¹⁴

The case for change (2008)

183. A discussion paper, *The case for change—Why England needs a new care and support system*, was published in May 2008. This referred to both the need for funding reform and the programme of “transformation”, in an apparent attempt by the DH to converge the two policy streams.

184. It was followed by a six-month public “engagement process”; and financial modelling was commissioned from the PSSRU. In the meantime, however, the Government continued to pursue some aspects of reform.

Reform of eligibility criteria

185. As we have noted, in October 2008 CSCI published a report, *Cutting the Cake Fairly*, which was highly critical of the operation of FACS. CSCI proposed adopting three new eligibility criteria bands, based on “priorities for intervention” to replace the current four bands based on risks to independence.²¹⁵

186. However, the DH concluded that it would be more cost-effective and cause less upheaval to retain the current eligibility criteria and focus instead on fairer and more transparent implementation, although there might be an argument for discontinuing the use of the fourth eligibility criteria band (Low). Draft revised criteria along these lines were put out to consultation during July–October 2009 and the outcome of this is still awaited.²¹⁶

Further development of personalisation

187. In June 2008 the NHS Next Stage Review Final Report, *High Quality Care for All*, announced that the DH would pilot models for new “integrated care organisations”, across primary, community and secondary healthcare and social care.²¹⁷ The Department would also pilot “personal health budgets” in the NHS, primarily in respect of people with long-term conditions, reversing its previous policy on this.²¹⁸

214 Department of Health, “Transforming Adult Social Care”, LAC (DH) (2008) 1, January 2008

215 The three eligibility criteria bands proposed by CSCI were:

- Immediate – without immediate support a person’s well-being would be immediately threatened;
- Early intervention – well-being may be threatened within six months without support; and
- Longer-term intervention – well-being may be threatened within a year without support.

216 Department of Health, *Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care: Guidance on Eligibility Criteria for Adult Social Care, England 2009 (consultation stage)*, July 2009

217 Department of Health, *High Quality Care For All: NHS Next Stage Review Final Report*, Cm 7432, June 2008, p 65; cf. Department of Health, *NHS Next Stage Review: Our vision for primary and community care*, July 2008, para 7.14. Sixteen Integrated Care Pilots were announced in April 2009 and began operating in July 2009. The programme was expanded in February 2010.

218 Department of Health, *High Quality Care For All*, Cm 7432, 2008, p 42. Cf. Department of Health, *NHS Next Stage Review*, 2008, para 4.30. The pilot programme began in 2009 and will run until 2012.

188. In October 2008 the results of the IBSEN study of the Individual Budgets pilots were published. The key findings were as follows:

- There was little difference in the average costs of IBs and conventional social care support. However, implementing IBs nationwide would require substantial investment, including in staff training.
- People using IBs were more likely to feel in control of their lives than people receiving conventional social care support.
- Satisfaction varied between client groups and was highest among mental health service users and physically disabled people, and lowest among older people.
- A substantial proportion of older people felt that taking control of their support was a “burden”.
- Staff encountered significant barriers to integrating funding streams.²¹⁹

189. In October 2008 Jeff Jerome was appointed to the new role of “National Director for Social Care Transformation”. This post is funded by the DH (through a “top slice” of the Social Care Reform Grant) and accountable to a “consortium” that includes the Department, the LGA, the Improvement and Development Agency and ADASS. The post is designed to support councils by offering leadership and guidance in implementing *Putting People First*.²²⁰ At the same time the DH published a leaflet, *Putting People First - the whole story*, which enumerated the four key aspects of “transformation”:

- Universal services;
- Early intervention and prevention;
- Choice and control; and
- Building “Social Capital”.

Shaping the Future of Care Together (2009)

190. The long anticipated Green Paper, *Shaping the Future of Care Together*, was published in July 2009; it was followed by a consultation (branded as the “Big Care Debate” by the Government), which ran until November 2009. The Government received 28,000 consultation responses and held 37 stakeholder events around the country.²²¹ A White Paper, setting out plans for legislation to reform social care, is expected imminently.

191. In the Green Paper the Government proposed a “National Care Service”, which would have six aspects as follows:

²¹⁹ Qq 778–781. Caroline Glendinning et al., *Evaluation of the Individual Budgets Pilot Programme: Final Report* (York, 2009)

²²⁰ Qq 88–89, 117, 843

²²¹ Q 889

- 1. Prevention services:** You will receive the right support to help you stay independent and well for as long as possible and to stop your care and support needs getting worse.
- 2. National assessment:** Wherever you are in England, you will have the right to have your care and support needs assessed in the same way. And you will have a right to have the same proportion of your care and support costs paid for wherever you live.
- 3. A joined-up service:** All the services that you need will work together smoothly, particularly when your needs are assessed.
- 4. Information and advice:** You can understand and find your way through the care and support system easily.
- 5. Personalised care and support:** The services you use will be based on your personal circumstances and need.
- 6. Fair funding:** Your money will be spent wisely and everyone who qualifies for care and support from the state will get some help meeting the cost of care and support needs.²²²

192. This will constitute a “universal offer”,²²³ meaning that social care becomes truly a service for everyone rather than the residual or “safety net” service that it has hitherto been. The Government states in the Green Paper that:

We believe that the care and support system should give everyone some help with meeting their needs. Everyone should get support to stay independent and well. Everyone should be able to have access to information and advice about care and support. If their needs qualify for further assistance, everyone should get financial help in meeting the cost of care and support.²²⁴

We believe that the new National Care Service must be a system for everyone. It must help everybody to find and obtain the good-quality care and support they need so that they can live their lives the way they want to.²²⁵

193. The Secretary of State has told the House that it is:

no exaggeration to say that the Government’s Green Paper “Shaping the Future of Care Together” is a Beveridge moment for social care. It is a chance to rebuild the social care system from first principles[.]²²⁶

As he reiterated in evidence to us, he wants to build on the basis of the Green Paper “unstoppable momentum” for legislation in the next Parliament.²²⁷

222 Department of Health, *Shaping the Future of Care Together*, Cm 7673, 2009, p 47

223 Q 16

224 Department of Health, *Shaping the Future of Care Together*, Cm 7673, 2009, pp 47–48

225 *Ibid.*, p 65

226 HC Deb, 29 October 2009, col 484

The National Care Service consensus

194. On the key aspects of the National Care Service set out in the Green Paper a widespread consensus is apparent. Below we look at each of these aspects and the points around which there is consensus.

Focus on prevention

195. We heard from Jeff Jerome, the National Director for Social Care Transformation, that local authorities had hitherto approached the issue of prevention in a very broad and general way, in relation to the general provision of collective services such as “employment, education, transport, suitable housing, and information and advice as well as good health improvement programmes”.²²⁸ Now a more targeted and individualised approach was being promoted:

We would look at individual need and assist people to identify whether there was any potential for them to improve well-being and independence and there would be targeted programmes.²²⁹

196. Mr Bolton, from the DH, indicated that the evidence base in this area was still being developed, but some piloting was taking place:

The POPPs pilots [...] of which we are about to see the final results, has been a major study into the impact on people of those kinds of schemes. I think the evidence is going to show us they have a particularly positive impact in reducing people’s need for healthcare.²³⁰

197. As we have noted, our evidence indicated that a significant weakness in the current social care system is the lack of a major and coherent focus on prevention. We were told about the benefits that could accrue from certain interventions, such as Telecare²³¹ and falls prevention,²³² and the particular importance for prevention of appropriate housing provision, integrated with social care.²³³ Mr Harrop, of Age Concern and Help the Aged, also underlined the importance of involving agencies beyond social care and suggested some of the cost should be borne by them, particularly the NHS “because they get an awful lot of the benefits from both primary and secondary prevention”.²³⁴

227 Q 892; cf. HC Deb, 29 October 2009, col 484

228 Q 124

229 *Ibid.*

230 *Ibid.*; cf. Q 135, 136

231 Ev 27; Q 675. Telecare is a form of telecommunications technology, involving devices that can be triggered deliberately or automatically in the event of an incident such as a fall, summoning help. It allows someone with a social care need to continue living in relative independence despite having become more vulnerable.

232 Ev 24, 100, 142

233 Ev 24; Q 675

234 Q 674

“Portable” assessment

198. Mr Behan told us that one reason the National Care Service would be fairer than the current social care system was that it would include:

a national assessment system which is portable so that, if a person moves from Durham to Devon, or vice versa, they can take that assessment with them.²³⁵

Alexandra Norrish, Head of Social Care Strategy at the DH, explained that this meant:

wherever you have your assessment carried out in the country, you know that you have a right to receive services that meet your needs wherever you move to [...] you will then have a right to have your needs met and be sure that you do have that flexibility. You have the ability to move around the country for employment, or for whatever reason, in the way that most of us would take for granted.²³⁶

199. The principle of a nationally portable assessment was universally welcomed in all the evidence we received. However, the question of entitlement to care and support on the basis of such an assessment was more controversial, as we discuss in the next chapter.

Joined-up services

200. In its memorandum of evidence, the DH told us it was pursuing:

More joined-up working between health, housing and social care services and between social care and the disability benefits system [...] This would not necessarily involve structural change but improved joint ways of working to help to transform the experience of people who need care. The recently established Ministerial Group on Integration of Health and Social Care Services²³⁷ will help identify what has worked well in places round the country, as well [as] current evidence to help push forward joined-up working.²³⁸

201. Mr Behan cited several local examples of social care services working well with the NHS and other partner agencies. On the prospects for future joint working, he told us:

The vision that we have in the new system is that the [health and social care] systems will be drawn together and we need to build on the work that is already there. There are many tools that are currently available that draw services together but there is a strong signal in the Green Paper that we need to do more of this and this needs to progress more quickly.²³⁹

202. However, Mr Jerome added that the relationship between the NHS and social care remained “really very, very complicated” and was “particularly difficult around long-term

235 Q 14

236 Q 15

237 This Group was created in 10 March 2009 and had met four times by December 2009 (HC Deb, 9 November 2009, col 121W and 16 December 2009, col 1321W).

238 Ev 3

239 Q 143

conditions and long-term care funding”. He thought that “On the ground that is sometimes difficult for people to address”.²⁴⁰

203. The idea of more joined-up care was welcomed in the evidence we received and some successful forms of integration were mentioned, such as multi-service “one-stop shops” and the co-locating of different types of service.²⁴¹ However, as the King’s Fund pointed out to us:

The promise that people will enjoy “joined-up services” is laudable but the means whereby this will become a consistent reality have yet to be specified.²⁴²

Citizen’s Advice likewise told us:

[what the Green Paper says on joined-up care] looks highly desirable, but the difficult question is how this is to be achieved. The green paper has little to say about this beyond saying that people should be assessed for all forms of support at a single assessment, which only addresses one aspect of the issue. It appears that we must wait to see what the new Ministerial Group on Integration of health and Social Care Services comes up with.²⁴³

Information and advice

204. In the implementation of *Putting People First*, information and advice are included as part of “universal services”, one of the four areas on which councils have been told to focus. Ms Norrish, of the DH, explained to us the importance of information and advice as part of the “universal offer” of the National Care Service:

We have spoken to many, many people who have said they have tried to approach their local authority for information or for help and in some cases they have had no response at all, in some cases they have been signposted on to Age Concern or one of the organisations in the voluntary sector. I think what to move to a universal system does is it breaks down that barrier; it moves away from a system which only some people, the poorest essentially, are sure that they are going to get any help from the state into a service where everyone in the country who has a care need is entitled to at least advice support from the state.²⁴⁴

205. As we have noted, our evidence underlined how far many councils must progress in ensuring everyone can access appropriate information and advice about the options available to meet their care and support needs.

206. Although there is widespread support for the principle of universal access to information, the means of achieving this are not necessarily obvious. While the idea of “one-stop shops” appears popular,²⁴⁵ we received evidence from the Princess Royal Trust

²⁴⁰ *Ibid.*

²⁴¹ Ev 96–97 and 101

²⁴² Ev 78

²⁴³ Ev 136

²⁴⁴ Q 63

²⁴⁵ Ev 128, 137

for Carers warning that this must not be seen as the only solution (since “if you miss the door, then you’ve missed the chance”). The Trust told us “There needs to be a variety of information gateways, national and more locally targeted”.²⁴⁶

Personalised care and support

207. The DH explained to us as follows the relationship between the Green Paper and *Putting People First*:

some of the problems in the current system will extend beyond the timescale of *Putting People First*. They will need a longer-term, national approach to providing care and support. The Green Paper builds on the approach that *Putting People First* developed and goes further to ensure in future everyone will be eligible for help with finding and paying for the care they need. In addition, an individual’s care and support plan, will give much greater choice over how and where they receive support, and the possibility of controlling their own budget wherever appropriate. This means that people will know what resources they have available and that they will be able to make decisions about how it is used. This system will be the same regardless of where people live.²⁴⁷

208. During the course of the Green Paper consultation the DH pushed on with this aspect of reform. In September 2009 it agreed with ADASS and the LGA the key priorities for the first phase of transformation (by April 2011), with “milestone” dates (see Appendix 1).²⁴⁸ In January 2010 the Department published *Putting People First: Personal budgets for older people—making it happen*, a guide to assist councils and partner organisations in developing choice and control for older people who use social care services.

209. The continued emphasis on personalisation was universally welcomed in the evidence that we received. Mencap, whose views were quite typical, told us that it:

fully supports personalisation as it reinforces the idea that the individual is best placed to know what they need and how those needs can be best met. Personalisation is about giving people greater choice and control over their lives and replaces traditional and institutional care services.²⁴⁹

However, many aspects of the actual implementation of personalisation were contentious, as we discuss in the next chapter.

A more universal funding system

210. Part of the “universal offer” of the National Care Service is that everyone who is eligible for care and support will be entitled to some element of state funding. This would be in contrast to the current system, under which means-testing excludes many people, including those with relatively modest means, from receiving any state funding at all. It

246 Ev 121

247 Ev 2

248 Qq 90–93, 843

249 Ev 7

would also go some way to addressing the perceived unfairness of local variations in funding, since, as the Green Paper states, “you will have a right to have the same proportion of your care and support costs paid for wherever you live”.²⁵⁰

211. In the evidence that we received we found no hostility to the idea of moving to a more universal system of “fair funding”. This is not surprising given that the current system is very widely seen as confusing, unfair and a disincentive to saving for older age. However, as we explain in the next chapter, the specific options set out in the Green Paper proved extremely contentious.

More support for carers

212. Mr Behan acknowledged that the high level of unmet need under the current social care system meant that “the informal care system will often have to do a lot of the heavy lifting of care, providing that day-to-day care”. The Government did have a Carers Strategy,²⁵¹ which “was designed to help to continue to support carers, to enable informal carers, unpaid carers to continue to provide that care”. However, “the balance between the formal care system and the informal care system has changed over recent years” and this needed to be addressed.²⁵²

213. The Green Paper indicates how the National Care Service could “in many ways” help to redress that balance. Carers’ loved ones would be able to access care and support more easily; better care and support would be ensured; and fair funding would particularly help carers whose loved ones currently receive no state funding.²⁵³

214. The Secretary of State admitted to us that the Green Paper had not put the needs of carers sufficiently to the forefront and emphasised that:

the state needs to do more to make life tolerable for them so they can care and raise their own children or go to work and I believe that today we are not doing enough in that regard.

He promised that this would be fully addressed in the White Paper.²⁵⁴

215. The Secretary of State also told us that he did not accept the view, put forward by some commentators, that if the state provides more care and support, many people will shirk their personal responsibility to act as carers.²⁵⁵ Greater public provision was not about

250 Department of Health, *Shaping the Future of Care Together*, Cm 7673, 2009, p 47

251 The Government’s interdepartmental Carers Strategy was relaunched in 2008. The Strategy sets out the Government’s short-term agenda and long-term vision for the future care and support of carers, underpinned by £255 million, to fund some immediate measures (Department of Health, *Carers at the heart of 21st-century families and communities: “A caring system on your side. A life of your own”*, June 2008).

252 Q 6

253 Department of Health, *Shaping the Future of Care Together*, Cm 7673, 2009, p 20

254 Q 875

255 See, for instance, Melanie Phillips, “An uncivilised attitude towards the old”, *Daily Mail*, 18 November 2009; cf. “Unreal Politics” (editorial), *The Times*, 19 November 2009.

impinging on the “proper preserve of families, relatives, communities and neighbours”, he said, but about helping carers both to care and to live their own lives.²⁵⁶

216. Our evidence indicated that there is a very strong consensus in support of this approach, as summed up for us by Ms Redmond, of Carers UK:

You do not need to encourage [carers] to love their families more; you just need to make sure they get proper breaks and that they get proper assistance, proper help. That is all you need. It is an enabling role that the state should be in [...] We just need to be on the side of families. I do not see them shirking their responsibilities.²⁵⁷

Mr Wittenberg’s evidence indicates that there is a good evidence base to back this up:

supposing formal care increases, do the informal family carers drop out? The literature of which I am aware suggests no, they do not drop out. They may reduce the hours a bit but not hugely and they may change exactly what they do [...] Professor David Bell commented in his report that the expansion of home care linked to the free personal care in Scotland appears not to have caused family carers in Scotland to drop out of providing care.²⁵⁸

A sound evidence base

217. The Green Paper states that:

Although the evidence base is improving, there is still not enough information as yet on how to spend money most effectively in care and support. This is vital to ensure that people can get high-quality services that they can trust to meet their needs. It is also crucial if services are going to work well first time and give good value for money—whether they are paid for by taxpayers or people who need care and support.²⁵⁹

218. Accordingly, it advocates the creation of an independent body to provide advice on the effectiveness and cost effectiveness of services, fulfilling a similar role to that of the National Institute for Health and Clinical Excellence in the NHS. The Green Paper leaves open the question of whether this should be a new body or whether the remit could be filled by an existing body, such as the Social Care Institute for Excellence (SCIE).²⁶⁰ To the extent that this proposal was mentioned in the evidence that we received, by SCIE and the CQC, it was welcomed.²⁶¹

256 Q 876

257 Q 758

258 Q 204. The Wanless report came to a similar conclusion: “Many decide to care with little regard for ‘substitution potential’ of formal care and are motivated by many factors other than the provision of formal care or lack of it” (Derek Wanless, *Securing Good Care for Older People: Taking a long-term view*, 2006, p 151).

259 Department of Health, *Shaping the Future of Care Together*, Cm 7673, 2009, p 44

260 *Ibid.*, p 79. SCIE was established by the government in 2001 to improve social care services for adults and children in the UK. SCIE does this by identifying and spreading knowledge about good practice; it is an independent charity, funded by the DH and the devolved administrations in Wales and Northern Ireland.

261 Ev 85, 147

Law reform

219. Since the passing of the National Assistance Act 1948, which remains in force, the law underpinning the social care system has evolved into a complex and unwieldy structure, as the Law Commission noted in 2008:

The legislative framework for adult residential care, community care and support for carers is inadequate, often incomprehensible and outdated. It remains a confusing patchwork of conflicting statu[t]es enacted over a period of 60 years. There is no single, modern statute to which service providers and service users can look to understand whether services can or should be provided, and what kinds of services [...] In addition to a number of different statutes, there is also a great deal of “soft law” in the form of guidance and departmental [i.e. DH] circulars.²⁶²

Much of the existing law embodies outdated attitudes towards people with care and support needs that are at odds with current policy and modern thinking about equality, human rights, dignity, personalisation and autonomy (the 1948 Act, for instance, refers to “dumb and crippled persons”).

220. The Law Commission is committed to the reform of social care law and is currently consulting about options for reform, with a view to publishing a final report in 2011.²⁶³

Conclusions

221. **Social care reform has two interrelated strands: the first concerned with how care and support are funded and the second with how they are commissioned and provided. When the Government took office in 1997, it stated that the first of these was one of its major priorities. Yet it took until 2009 for the Government to set out a range of options for fundamental reform, in the Green Paper *Shaping the Future of Care Together*. This came so late in the present Parliament that the White Paper containing the Government’s plans for change will be published just weeks before a general election, with no prospect of legislation until the next Parliament. The problems, and the options for solving funding reform, have long been known; and prime opportunities to initiate reform (a Royal Commission in 1999 and major reform proposals resulting from independent reviews) have been squandered. The failure to grasp this nettle is sadly indicative of the low priority given to social care by successive administrations and this must not continue.**

222. **On the second strand of reform, how care and support are commissioned and provided, the Government has made better use of its time in office, initiating a programme of “transformation” with potentially far-reaching consequences. We strongly welcome the focus on personalisation as the way forward, although we recognise that there is still a long way to go before all councils are offering genuinely self-directed support.**

262 Law Commission, *Adult Social Care: A Scoping Report – Summary*, November 2008, para 1.3

263 www.lawcom.gov.uk/public.htm

223. The Green Paper *Shaping the Future of Care Together* sets out the Government's vision for a National Care Service, embodying both strands of reform. The following major elements of this vision have attracted practically universal consensus and we too strongly endorse them:

- A focus on prevention, rehabilitation and re-ablement;
- A “portable” national assessment, backed up by national uniformity in the proportion of care and support costs being paid for from public funds;
- A more joined up service, with social care, the NHS, housing support services and the social security benefits system all better integrated;
- Easy access to information and advice for everyone, regardless of their circumstances;
- Personalised care and support, so that the needs and aspirations of each individual person are met;
- A more universal funding system, ending the situation where many people get no support at all from public funds;
- More support for carers, recognising their vital role, supporting them and ensuring that they are not obliged to take on too much responsibility for care;
- Building a sound evidence base on the effectiveness and cost effectiveness of different forms of care and support.

224. The current social care system is complex and opaque. This is substantially down to the fact that it has been the subject of countless piecemeal reforms since its creation in 1948. It is underpinned by an outdated structure of numerous Acts of Parliament, case law, regulations, directions, guidance and circulars, much of which are anachronistic and inconsistent with current policy and modern thinking about equality, human rights, dignity, personalisation and autonomy.

225. We welcome the Law Commission's commitment to thorough reform of social care law to ensure it becomes consistent, coherent and up-to-date. We recommend that the National Care Service be built on fresh legislative foundations, rather than created through further modifying and patching the existing framework, which is clearly no longer fit for purpose.

226. The Government needs to build on the existing consensus about reform to ensure that the National Care Service becomes a reality. However, as we discuss in the next chapter, before it can do so it must resolve a number of other, fundamental, issues on which there is as yet far from being consensus.

6 Achieving lasting reform

227. In this chapter we examine the key issues of social care reform that remain controversial and the reasons why they continue to be major obstacles to reform.

Funding

228. The most contentious part of social care reform is the issue of funding, which underpins all other aspects of reform. Below we examine why consensus on this issue has not yet been achieved.

Funding options

229. The Green Paper sets out five possible funding options for social care, each with the potential to bring in additional funding, which it explains sit “on a continuum”.²⁶⁴ At one end of this is a **Pay for yourself** system, where everybody would be responsible for paying for their own basic care and support, whether through insurance or savings. This is ruled out on the grounds that it would leave many people without the services they need.

230. At the opposite end of the continuum is a **Tax-funded** system, free at the point of use. This too is ruled out, on the grounds that it:

- would place “a heavy burden”²⁶⁵ on people of working age;
- would be unsustainable, due to the projected worsening of the old age support ratio;
- would allow older people to get more out of the system than they paid in; and
- does not allow for the fact that older people have benefited disproportionately from house-price inflation (holding £932 billion in housing assets in 2004), while people of working age are disadvantaged by high property prices.²⁶⁶

231. Three further funding systems, sitting between these two extremes, are put forward by the Green Paper as options for debate:

- **Partnership**

Everyone who qualified for care and support would receive state funding for a proportion of the cost of their basic care and support (for example a quarter or a third), or more if they had a low income. They would have to pay the rest themselves, effectively as a co-payment or user charge. The Green Paper indicates that the majority of working-age adults who need care and support would not have to pay under this system because younger disabled

264 Department of Health, *Shaping the Future of Care Together*, Cm 7673, 2009, p 100

265 *Ibid.*, p 18

266 Department of Health, “Impact Assessment of the Care and Support Green Paper”, July 2009, p 46

people tend to have low incomes and few assets. The DH told us that this option was based on the funding model developed by Sir Derek Wanless for the King's Fund.²⁶⁷

— Insurance

This is the same as the Partnership model, but with an element of voluntary insurance to cover individuals' contributions in the event of their needing care. This could be a state insurance scheme, or one developed with the private insurance market. With the state guaranteeing to pay part of the cost of care, premiums for private insurance would be lower than in a purely private system. The Green Paper estimates that the total insurance premium would be between £20,000 and £25,000 (compared with the average lifetime cost of care for a 65-year-old of £30,000);²⁶⁸ this could be paid in instalments or in a lump sum, before or after retirement. This option is not for working-age adults, since they would not be able to insure against the care needs that they already have. It appears to be presumed that they would mostly qualify for free care on the basis of means-testing, as under the Partnership option.

— Comprehensive

Everyone over retirement age, apart from the poorest, would be required to pay into a state insurance fund; the contribution could be set at a flat rate or varied according to people's ability to pay. Everyone would then receive free care and support if they needed it, paid for from the insurance fund. The Green Paper estimates that the total contribution from each person would need to be between £17,000 and £20,000. The cost would be less for people who were already aged over 65 when the scheme was introduced. It is suggested that couples might make lower contributions, in recognition of the extent to which people within couples act as each other's carers. The Government would consider having a free care and support system for people of working age alongside the Comprehensive option for older people.

Ms Norrish, of the DH, told us that all the shortlisted options were based on the principle of progressive universalism, with all eligible people receiving some state help but less well off people receiving more help than others.²⁶⁹ The National Care Service would thus not be a fully universal service like the NHS (despite the, presumably intentional, similarity in names).

232. None of the funding options is intended to cover "hotel costs" for people in residential care, which would continue to be the responsibility of individuals (with means-tested help available for the poorest). The Green Paper states this is "because we would expect people to pay for their own food and lodging whether or not they were in a care home".²⁷⁰

267 Q 42

268 The PSSRU has calculated that on average at age 65 a person can expect to need (FACS eligible) social care, of all types, worth £31,700 (not including "hotel costs" in residential care) during the rest of their life. Around a quarter will need no care, or support with a minimal cost (equipment only); 10% (mostly long-stay care home residents) will need care worth many tens of thousands of pounds (Julien Forder and José-Luis Fernández, *Analysing the costs and benefits of social care funding arrangements in England*, 2009, Table 21, p 26).

269 Q 16

270 Department of Health, *Shaping the Future of Care Together*, Cm 7673, 2009, p 16. In taking this position, the DH is actually following the same line as the Royal Commission on Long-Term Care. The current system effectively makes

233. It also states that, in recognition of the difficulty of meeting these costs, they could in future be met by means of a “universal deferred payment mechanism”,²⁷¹ so that payment could be taken from people’s estates after their death. (Although councils currently have the discretion to offer this option, around a fifth do not.)²⁷² This mechanism could potentially also be used to meet co-payments under the Partnership and Insurance options, or the one-off insurance contribution under the Comprehensive option.

Responses to the options

234. It is widely agreed that the Government is correct to rule out the **Pay for yourself** option. In our evidence we heard that private insurance against care and support needs has long been characterised by “market failure”. This is due to low take-up (because few people expect they will need care) and “adverse selection”, i.e. the fact that people who are more likely to need care are more likely to buy insurance (which skews the “risk pool” of any insurance fund). These factors drive up premiums and make this form of insurance at best a niche product for better off people (e.g. immediate needs care annuities),²⁷³ or at worst commercially unviable.

235. We also heard there is scepticism in the insurance industry itself about the Conservative Party’s plan for a privately-run insurance scheme to cover residential care at a premium of just £8,000. Chris Horlick, of Partnership Life Assurance Company Ltd (a provider of immediate needs care annuities), welcomed the idea of exploring funding options involving the private sector, but on this specific proposal told us:

I think there are some pretty flawed assumptions in it and the two most fundamental ones are the numbers of people going into care, so the front end bit of it, if you like, and at the other end their longevity in care. I have not seen the model so I do not understand the details of it but it seems to me to be flawed, I am afraid [...]²⁷⁴

236. There was general agreement that it was desirable to have a more universal system than the status quo (in which many people receive no state support at all), but beyond that opinions differed.

237. A wholly universalist system (i.e. the **Tax-funded** option) had considerable support among those who gave evidence to our inquiry. Its advocates pointed out that the three progressive universalist options put forward for consideration in the Green Paper “all continue to involve an element of means-testing and unfairness”, as the National Pensioners Convention told us.²⁷⁵ The Tax-funded option, by contrast, would be a truly fair and equitable way to pay for care and support. It would enable “risk pooling” right across

even the poorest of residents contribute towards “hotel costs” by taking all their income, bar the nominal amount represented by the PEA.

271 *Ibid.*, p 20

272 In 2007–08 around 80% did so, according to data supplied by councils in response to Freedom of Information requests (www.channel4.com/news/articles/society/elderly+forced+to+sell+homes+to+pay+care+costs/2913557).

273 Immediate needs care annuities are bought at the point when a person has developed a care and support need and they provide a guarantee of care until death. The product is individually underwritten, so the premium can vary substantially, but it can cost as much as £80,000. The main provider of this product has insured just 5,000 people in 10 years (Ev 97–99; Qq 549, 555–561 and 644–646).

274 Q 579

275 Ev 65

society, with people contributing, through the tax system, on the basis of their ability to pay and receiving care and support solely on the basis of need. This approach is supported by all the main political parties, and the great majority of the public, as the underpinning principle of the NHS and many cannot see why it should not apply to social care too.²⁷⁶ It is notable that the DH's own polling shows that half of people asked think social care is already provided on the same basis as the NHS.²⁷⁷

238. In attempting to justify funding social care in a different way to the NHS, the Secretary of State referred to people accepting personal responsibility for aspects of social care and to the extent of home ownership nowadays.²⁷⁸ Yet variants of these arguments could just as easily be deployed against the principle of a free NHS. Mr Humphries, of the King's Fund, thought the Green Paper made a "cogent" case for believing tax-funded social care would be unsustainable, but could not see why this did not apply equally to the NHS. He concluded: "Some of this does boil down to political choices about what you want to do out of taxation or not, as the case may be".²⁷⁹

239. Support for the **Partnership** form of progressive universalism put forward in the Green Paper did not seem strong in the evidence we received and it attracted a number of criticisms. Linda Pickard, of the PSSRU, told us that it could lead to heavy reliance on carers, since "many of those without sufficient financial resources to purchase care services would seek support from their families". This would make the social care system vulnerable in the future to declining availability of informal care.²⁸⁰

240. Professor Caroline Glendinning, of York University, told us that the Partnership model:

may be very difficult to operationalise with people who have very significant fluctuations in their conditions, or deteriorating conditions, where the amount of money that would be contributed may well change from time to time and, indeed, on a very frequent basis [...]²⁸¹

241. Mr Laing, of Laing & Buisson, argued that this option would constitute a *de facto* continuation of the current means-tested system. While better-off people would receive some state funding, this would be offset by the impact of reforming Attendance Allowance (which is currently payable as a non-means tested benefit to self-funding care home residents): "that is smoke and mirrors; no change at all!"²⁸²

242. Another weakness in the Partnership model is that, as under the current system, there is no cap on the amount that a person could end up paying from their own resources, should they need care that is very expensive by reason of its type or duration.²⁸³ There is

276 Ev 14, 15, 16, 46, 61, 65, 66, 67, 72, 84, 102, 104, 106, 107 and 134; Qq 458, 642, 729, 760, 766, 808–809; SC 19A

277 Q 16

278 Q 924

279 Q 255

280 Ev 46

281 Q 760

282 Q 552

283 Q 237

some indication that the relatively low level of state contribution for some people in the Green Paper's version of the Partnership model (at least a quarter of each person's costs) would leave significant numbers facing substantial co-payments at the point of need.²⁸⁴

243. Although the DH insisted its version of the Partnership option was essentially the same as Sir Derek Wanless's, we heard that there were crucial differences and Sir Derek's proposal may have more support. Sir Derek's version of the Partnership option involved state funding of two-thirds of the cost of a benchmark package of care, with the remainder paid for by co-payments, along with further pound-for-pound "match-funding" by the state (meaning that the state could contribute up to 83% of the cost in each case).²⁸⁵ Mr Humphries told us that the King's Fund thought match-funding, which was intended to give people an incentive to make provision for themselves, was "an important component of the original partnership".²⁸⁶ Another difference is that Sir Derek's proposal involved higher quality benchmark packages of care than does the Green Paper, which simply assumes that care packages will be worth their current value.²⁸⁷

244. The **Insurance** option is a variant of the Partnership option and, as such, is susceptible to the same criticisms. In addition, it is improbable that the voluntary insurance element of the Government's Insurance option would actually attract significant numbers of people, since it would fall foul of the problems that have always beset private insurance (i.e. low uptake and adverse selection).

245. The **Comprehensive** option found some support among our witnesses because it would effectively "cap" people's contributions from their own resources, unlike the two co-payment options (Partnership and Insurance), as well as spreading risk significantly more widely than those options.²⁸⁸

246. The charity Counsel and Care supported the Comprehensive option, seeing it as close in spirit to the Tax-funded option (which Counsel and Care also favoured). The charity thought that the Comprehensive option would operate most fairly by means of a "care duty" of 2.5% on people's estates (with perhaps a threshold of £25,000 below which assets were disregarded), to be hypothecated, i.e. paid into a ringfenced fund for social care expenditure.²⁸⁹ There has recently been political controversy about the possibility that the Government will favour this form of the Comprehensive option, which has been criticised as a "death tax". From this point of view, it is regarded as effectively an additional form of Inheritance Tax, which would hit people hardest in London and the South East, where property values are highest. However, a recent Care and Support Conference, involving a range of stakeholders was favourably disposed to it, while also regretting "that the option of general taxation had not been explored".²⁹⁰

284 Q 273

285 Q 273. The JRF suggested that the state should pay 80% of each person's costs under a co-payment model.

286 Q 233; *cf.* Ev 78

287 Q 240

288 Ev 25, 67–68, 70, 104, 119, 125

289 Ev 125; Qq 647–649

290 Consensus Statement, Care and Support Conference, 19 February 2010

247. Others who were also sympathetic to the Tax-funded model have been less positive about the Comprehensive option.²⁹¹ While Ms Pickard thought that, of the options in the Green Paper, only the Comprehensive one “would potentially reduce reliance on intense informal care” (since there would be no financial disincentive to accessing care and support), she added:

It is not clear, however, that a “comprehensive” option should necessarily be funded only by the resources of older people themselves, as is suggested in the Green Paper. There are many organisations representing older people who feel that tax-funding of social care should not be ruled out and that “costs must be shared fairly across the generations”.²⁹²

Professor Glendinning pointed out to us that in Germany, where social care is funded through a social insurance scheme, contributions are paid by the working age population and this is generally accepted.²⁹³

248. Age Concern and Help the Aged reported that: “our research shows that the proposal for a ‘care charge’ outlined in the ‘comprehensive’ option is very unpopular.”²⁹⁴ The charity calculated that overall (allowing for the reform of Attendance Allowance and “hotel costs”) the option was likely to prove:

little cheaper than insurance people can already buy to cap their costs, once they know they will need care [immediate needs care annuities]. We think few older people will see the care charge as a “price worth paying”.²⁹⁵

249. Mr Lloyd explained to us how “soft compulsion” might be used to avoid the pitfalls involved in both voluntary and compulsory insurance. This could be done by automatically enrolling everyone in a state insurance system, but giving people the choice to then opt out if they wished. Since most people would not trouble to opt out, this would give the broad coverage of compulsory insurance but would not be as strongly resented.²⁹⁶

250. The DH’s view that funding reform did not need to address “hotel costs” was widely criticised. It was pointed out to us that these costs can be much higher than the cost of living at home; and “hotel costs” can end up being catastrophic just as care costs can.²⁹⁷ We heard that in Scotland, despite free personal care, residents still pay substantial sums from their own resources to cover “hotel costs”.²⁹⁸ The independent consultant Donald Hirsch told us:

Is there not another way of looking at this and that is to say not an accommodation cost but an accommodation charge? [...] It certainly would not look right to have a

291 Ev 65, 134

292 Ev 46

293 Q 760

294 Ev 114

295 Ev 116; cf. 644–646

296 Q 251

297 Ev 67; Qq 653–659

298 Q 263

system which provides everything to people when previously they would have been paying for those things, food and accommodation, but if you could have a charge based on what people can pay, then you would not have this issue.²⁹⁹

People of working age

251. Another issue that caused concern was the Green Paper's failure to say enough on how the funding options would affect people of working age. It assumes that people of working age will mostly qualify for wholly free care under the Partnership option on the basis of means-testing. The charity Leonard Cheshire Disability told us:

We are very concerned that a means-test in the partnership model could have exactly the same effect as now, actively discouraging saving among disabled people who use care and support services, preventing many from going out to work and leaving more trapped in poverty.³⁰⁰

252. Regarding the Insurance option, the Green Paper indicates that this is for people of retirement age only (it would not be possible for people of working age to insure against an existing impairment). This appears to mean that, as under the Partnership option, working-age people would qualify for free care on the basis of means testing.

253. The Government says it would look at a free care and support system for people of working age alongside the Comprehensive option for older people. However, Leonard Cheshire Disability told us:

this brings its own complexities with regard to a subsequent point of transition being created between working age and older people's services, by requiring individuals to start paying for some or all of their care at the point when they are no longer earning a monthly income from work.³⁰¹

The overall "funding envelope"

254. The Impact Assessment for the Green Paper suggests that the National Care Service could cost the state annually between £18.2 billion and £20.7 billion by 2014 (in real terms at 2006 prices), depending on the funding option chosen. The Partnership and Insurance options would cost the state marginally more than the current system in 2014, and the Comprehensive option significantly more (£3.4 billion, i.e. the same additional cost as the Tax-funded option).³⁰²

255. These are "illustrative comparative costs suggesting the possible cost to the state of the different models",³⁰³ with the assumption that the budget for Attendance Allowance is

299 Q 287

300 Ev 103

301 Ev 104; cf. Q 256, Ev 144

302 Department of Health, "Impact Assessment of the Care and Support Green Paper", 2009, pp 9, 11. The Impact Assessment also gives the slightly different additional cost of £3.3 billion for the Comprehensive and Tax-funded options (*ibid.*, p 46).

303 HC Deb, 12 October 2009, col 758W

merged into social care funding (we discuss this proposal further below). They are, therefore, no indication of what the future “funding envelope” for social care will actually be.³⁰⁴ Thus, as ADASS noted in its evidence to us, the Green Paper:

is silent on the prospects of more state funding even though the options imply increased state expenditure and increased contributions from individuals.³⁰⁵

Yet, as we have noted, one of the greatest problems with the current system is the extent to which it is underfunded. Age Concern and Help the Aged stated in their evidence that:

The Green Paper proposals are broadly “revenue neutral” (except for the “comprehensive” option). But the care and support system needs more resources—even to respond to the needs of people who meet today’s means-test—in order to achieve better quality and earlier availability of services [...] Before we can make any meaningful comment on the funding options proposed in the paper we need more detail on the costing assumptions: the level at which eligibility criteria will be set; how much resource will be available per person;³⁰⁶ and the nature of the means-test [...]³⁰⁶

In giving oral evidence the charity’s representative, Mr Harrop, elaborated on this:

The critical issue that is missing from this Green Paper is the analysis of the problems of the current system, all those issues [...] about it not being available to enough people, the amount spent per service user being insufficient, all that is rolled forward into the Green Paper’s proposals. The Green Paper is mainly about extending the current offer to higher income groups, rather than deciding: are there enough services available, is the amount of resource in that total envelope sufficient? We say it is not.³⁰⁷

Mr Chidgey, of the Alzheimer’s Society, also explained:

the big worry for people is there is nothing in the proposals that they think very clearly describes: what are you going to get? Are you going to be able to get some respite care except in an emergency, which is often the case at the moment, some planned respite? Are you going to be able to get a little bit of help to get someone out of bed, and to involve them in some meaningful activity?³⁰⁸

256. However, when we pressed the Secretary of State on the future social care “funding envelope”, he could only tell us:

Obviously, those are decisions for the Treasury and the Chancellor. Spending on social care through local government is obviously a decision for the Chancellor when

304 Q 67

305 Ev 42

306 Ev 114, 115

307 Q 651

308 Q 609

the final spending review is completed [...] Obviously, we cannot prejudge spending reviews in future.³⁰⁹

Immediate reforms

257. While there is universal recognition of the need for fundamental reform, we heard in our evidence that there are several more limited reforms that could quite easily, and relatively cheaply, alleviate some of the worst aspects of the status quo.

Revising capital limits

258. When we asked Mr Burke, of Counsel and Care, about options for short-term reform, he told us:

what we have embarked upon is system wide reform and long-term reform, inevitably that will not happen for three or four years yet, so there are probably things that you could do in the short-term, so certainly increasing the [upper] capital limits [above which a person receives no state help; in 2009–10 set at £23,000], probably [to] £50,000 [...] that was the figure recommended by a recent commission on care from Hampshire County Council [...]³¹⁰

259. We also heard from Mr Hirsch that the JRF had looked at “suggestions of things you could do while you were fixing the present system in the long term”. The Foundation had concluded that one such measure would be to double the upper capital limit “so that at least people would feel they had something to preserve in a worst case scenario”.³¹¹ A case might also be made for concomitantly raising the lower capital threshold, below which a person may keep all their capital (in 2009–10 set at £14,000).

Capping individual liability

260. The charity Mind mentioned to us in its evidence the idea of a “limited liability” arrangement, whereby if someone is required to pay for care from their own resources before they qualify for public support, “the individual contributes only for a certain length of time”.³¹² In this way, liability is effectively “capped” and there is no chance of incurring unlimited catastrophic costs in the event of needing care that lasts for a long time.

261. Sir Derek Wanless’s report considered “limited liability” as a possible funding model, with a cap taking effect either after a specified period of time or after a specified sum of money had been spent. (It was rejected on the grounds that it would only protect the assets of those who have more than the limited liability threshold.)³¹³ It was also recommended

309 Q 912

310 Q 660

311 Q 274

312 Ev 73

313 Derek Wanless, *Securing Good Care for Older People*, 2006, p 232

for consideration by one of the two signatories to the Royal Commission minority report.³¹⁴

Universal access to deferred payment arrangements

262. As we have noted, local authorities currently have the discretion to offer a Deferred Payment Agreement (allowing people to avoid having to sell their home during their lifetime to fund residential care, should they fail the means test) but many do not. The Green Paper, as we have also noted, proposes that this should be made universally available to help people pay “hotel costs” (and possibly also co-payments or insurance contributions) under a new funding system. There is support for this proposal³¹⁵ and there would seem to be no reason it could not be implemented ahead of fundamental reform of the funding system.

Reducing the tariff income

263. The presumed “tariff income” on capital between the two thresholds (£14,000 and £23,000) in 2009–10 is set at a rate equivalent to an annual net interest rate of 20.8%, which is considerably higher than the current (March 2010) Bank Rate of 0.5%. Although the tariff income is not intended to represent actually available rates of interest, the very large discrepancy between it and currently available interest rates is forcing people to “spend down” their capital much more quickly than would otherwise be the case. Citizen’s Advice told us in their evidence that “The tariff income rate is much too high and should be reduced.”³¹⁶

Raising the Personal Expenses Allowance

264. The low level of the PEA for local-authority sponsored care home residents (£21.90 in 2009–10) is a source of particular resentment under the current system. We heard that this amount is far too low for people to be able to maintain their quality of life, for instance by purchasing equipment such as a specialist chair or services, such as foot care.³¹⁷ Mr Hirsch told us that the JRF had “thought roughly £20 a week was just not compatible with dignity and it would not cost a lot to double that in the overall order of things”.³¹⁸

265. The Government has, however, resisted demands to increase the PEA on the grounds that this would consume scarce resources but would not “increase the availability choice or quality of care services or support the transformation of adult social care provision”.³¹⁹

314 Royal Commission on Long-Term Care, *With Respect to Old Age*, 1999, paras 69–77

315 Ev 77, 125, 141–142

316 Ev 135

317 Ev 90–91, 134

318 Q 274

319 HC Deb, 27 January 2009, col 16WS

Conclusions

266. The Government's presentation of the funding options in the Green Paper is significantly flawed. The option of free care wholly funded from general taxation is ruled out by the Government on the grounds that it would place "a heavy burden" on taxpayers of working age. However, many of those who gave evidence to us supported this option and most of the arguments against it can be said to apply just as much to the idea of a free NHS. We recommend the Tax-funded option should be debated in order to gauge whether people are prepared to pay higher taxes for social care or wish to see tax revenue diverted to it from other areas of spending.

267. The DH told us that the Partnership option presented in the Green Paper derived from the model developed by Sir Derek Wanless. However, a key part of Sir Derek's model which is missing from the DH's is the idea of the state matching individuals' contributions pound-for-pound, on top of a basic state contribution, to provide an incentive for people to make provision for themselves. We believe that Sir Derek's original Partnership option should have been included in the debate.

268. We are dissatisfied with the Green Paper's approach to the issue of "hotel costs", which it excludes from the funding options "because we would expect people to pay for their own food and lodging whether or not they were in a care home". It can plausibly be argued that such costs are significantly higher in residential care than they would be in a person's own home. Funding reform that fails to address the risk of incurring uncapped catastrophic costs of this kind risks being quickly discredited and losing public support. The Government must look at options for dealing with this issue, such as an accommodation charge that takes account of people's ability to pay.

269. We are also concerned that the Green Paper pays insufficient attention to how the various funding options might affect people of working age who use social care services. The means-testing element of the "Partnership" and "Insurance" options would risk replicating the existing poverty trap in which many disabled people of working age find themselves. The proposed free system for people of working age alongside the "Comprehensive" option for older people would avoid the poverty trap. However, we are concerned that the transition from one system to the other at the age of 65 could mean that people become worse off merely by reason of growing older.

270. A major deficiency in the Green Paper is that it is silent on the question of the overall "funding envelope" for social care, i.e. how much money, from all sources, will be spent on people with care and support needs in future. This leaves the Green Paper unable to indicate the scope of the new system. The state of public finances as a result of the credit crunch, the bank bailouts and the recession clearly makes the question of future spending levels particularly problematic. However, the issue cannot be ducked. We need to know in hard cash terms what future overall social care funding will be.

271. Ahead of fundamental reform, there is scope to mitigate significantly the worst aspects of the existing funding system quickly and relatively cheaply. This is not to argue for minor change as an alternative to major reform, but rather to make the case for addressing some of the deficiencies as a matter of urgency. We recommend that the following measures be taken immediately:

- The capital thresholds in the means test must be substantially raised in order to ease the burden on people of relatively modest means.
- Consideration should be given to some form of “cap” to limit people’s liability to pay from their own resources before they qualify for public support.
- Universal access to the deferred payment mechanism (which allows people to avoid having to sell their home during their lifetime to fund residential care) must be introduced.
- The presumed “tariff income” on capital between the two thresholds is punitive must be substantially reduced.

The Personal Expenses Allowance for people in residential care is far too low and fails to ensure dignity or opportunities for people to maintain their social and family relationships. It must, as a minimum, be doubled.

Free Personal Care at Home Bill

272. Since the publication of the Green Paper, social care reform has been made more complicated by the Free Personal Care at Home Bill. Below we outline the Government’s proposals and examine reactions to them.

The policy

273. At the Labour Party conference in September 2009, the Prime Minister, Rt Hon Gordon Brown MP, unexpectedly announced that the Government would be introducing free personal care for those people with the highest levels of need being cared for in their own homes, beginning in October 2010.

274. The Personal Care at Home Bill was introduced into Parliament on 25 November 2009 and is currently making its way through the House of Lords.³²⁰ The Government has meanwhile consulted on proposed regulations to be made under the Bill, should it become law. It is proposed that free personal care at home should be given to people whose needs are classified as “Critical” under FACS and who need significant help with four or more personal care-related Activities of Daily Living.³²¹ There are also proposals regarding how resources will be allocated to individual people;³²² and the formula for distributing to councils central-Government funding earmarked for this purpose.³²³ In addition, the draft regulations would permit councils to make free personal care conditional on a person undergoing a period of intensive support or re-ablement for up to six weeks before having

320 Under section 15 of the Community Care (Delayed Discharges etc.) Act 2003 regulations can be made requiring certain social care services (including personal care at home) to be provided by local authorities free of charge, but not for a period longer than six weeks. The Bill amends the 2003 Act to enable regulations to be made requiring personal care to be provided free to persons in their own homes for an indefinite period.

321 On how this is defined, see Annex 1.

322 The Government proposes the following options: the setting of an indicative cash sum; the setting of an indicative range in cash terms; or allowing discretion to local authorities in each individual case.

323 The Government proposes the following options: using the existing Adult Social Care RNF; using amended Adult Social Care RNF; or using a new formula based on ELSA.

their care and support needs formally assessed. A consultation on these proposals took place between 25 November 2009 and 23 February 2010.

275. The Government estimates that more than 400,000 people will benefit from this policy, with 130,000 people receiving re-ablement services and 280,000 actually receiving free personal care. Of those who will receive free personal care, 166,000 already receive free care after means-testing and 100,000 currently pay charges, receive informal care, receive residential care, self-fund or have unmet need.³²⁴

276. The cost is estimated at £670 million per annum, of which £420m will be supplied by the DH (from efficiency savings). In a recent interview, the Secretary of State said £60 million would be “re-prioritised” by the DH from “lower-priority” health research and development, and £50 million saved from public health campaigns as part of funding free personal care at home.³²⁵

277. He explained to us that these figures related to the first six months of implementation (the second half of 2010–11), during which the DH would have to find £210 million to fund the policy. He said that the Department planned to “release savings from the administration of the research budget”, but strongly denied that “front line research into cancer or other high-profile conditions” would be cut, as had been reported. However, he could not yet give “a precise list of the implications” of the planned savings. As regards public health campaigns, he suggested that cuts could be made in “how we procure advertising and communication space from the media” and by “taking a very tough approach to the use of management consultancy”.³²⁶

278. Local government will be expected to find the remaining £250 million, also from efficiency savings. The Secretary of State referred us to the DH’s document *Use of Resources in Adult Social Care* (October 2009), which he said “identified £250 million efficiency savings that we believe are there to be made”, a figure that had been confirmed in the Pre-Budget Report in December 2009.³²⁷ The latter states that local authorities could, by 2012–13, save:

£250 million from reducing variations in spend on residential care, including greater use of preventative approaches to care for older people allowing people to stay longer in their homes³²⁸

279. The Government argues that the Bill does not in any way cut across the Green Paper but is rather, as the Secretary of State put it to us, “a stepping stone or bridge” to the National Care Service.³²⁹ He argued that it did so firstly by ending the current “lottery” of

324 Department of Health, “Impact Assessment of the Care and Support Green Paper”, 2009, p 7

325 “Cancer research at risk in scramble for care funds”, *The Times*, 25 November 2009

326 Qq 907–911

327 Q 905; cf. Q 901

328 HM Treasury, *Securing the recovery: growth and opportunity – Pre-Budget Report*, Cm 7747, December 2009, p 110; cf. HC Deb, 6 January 2010, cols 470–471W

329 Q 900; cf. HC Deb, 14 December 2009, col 665

care for the most vulnerable and replacing it with a national entitlement to free care; and secondly by linking domiciliary care with re-ablement and a preventive approach.³³⁰

280. Following the announcement of this policy, the DH commissioned revised financial modelling from the PSSRU.³³¹ We twice wrote to the Secretary of State asking him to show us the interim financial model that the DH had received from the Unit in November 2009, but he declined to do so.³³² He denied this was because he was embarrassed to admit that the change in policy had badly damaged the DH's original calculations.³³³

Reactions to the policy

281. The Government's free personal care at home policy has proved to be extremely controversial. Lord Lipsey, who was a dissenting member of the Royal Commission on Long-Term Care, memorably accused the Prime Minister of being like "an admiral firing an Exocet into his own flagship" when the policy was included in the Queen's Speech.³³⁴ In our evidence we heard a number of reactions to the policy, both positive and negative (although largely the latter), and these are summarised below.

Relationship to the Green Paper

282. The Secretary of State insisted that free personal care at home had grown out of the Green Paper and not been "unilaterally chucked in";³³⁵ and DH officials insisted to us that the new policy had not been unexpected.³³⁶ However, considerable surprise has been expressed at the announcement of the policy in the middle of the Green Paper consultation (the Big Care Debate). Ms Scott, of the National Care Association, told us:

I thought we were in the middle of a public consultation about the whole issue, and so it was quite a shock, in the first instance, to have the announcement made [...] This is a large amount of money that has been dedicated, and we truly believed that we were having this major public consultation which would make these sorts of decisions. So this large amount money that is being allocated to one part of the service makes us think that other parts of the service may not be so fortunate.³³⁷

Mr Burke, of Counsel and Care, was sympathetic to the policy but thought:

the question is where are we heading generally, because we are obviously halfway through a Green Paper consultation on the future of care which is talking about system-wide reform, and that is what we need, we need to reform across the whole system. So a piecemeal change is not necessarily the best way to approach this.

330 Q 899

331 Q 44

332 Letters from the Secretary of State for Health to the Chairman of the Health Committee, 10 November 2009 and 8 December 2009

333 Q 902

334 "Labour peers savage Brown's free care plan", *The Times*, 19 November 2009

335 Q 900

336 Q 45

337 Q 459

283. A key point here is the perceived contradiction between free personal care at home and the categorical ruling out of the Tax-funded option by the Green Paper, as we heard from Professor Peter Beresford, of Brunel University:

if we have ruled out as an option considering general taxation in a Green Paper to which there have been 24,500 responses, a significant number of which have supported the idea of general taxation at least to be included, then it feels like it is policy being made on the hoof to introduce a new idea which contradicts that [...] ³³⁸

Scope of the policy

284. The narrow scope of the policy, as outlined in the proposed regulations, has caused concern. Mr Harrop, of Age Concern and Help the Aged, thought the policy was “a really welcome move forward” but noted that the proposed eligibility threshold meant that:

you really will need to be very, very disabled and in need to get this free offer [...] the people who are going to be supported by this actually could be relatively few in number. ³³⁹

There is a particular concern that people with fluctuating needs could be disadvantaged by the tightness of the eligibility criteria. ³⁴⁰

Unintended consequences

285. The piecemeal nature of this reform raises concerns that it could have unintended consequences in interacting with the rest of the social care system. Mr Chidgey, of the Alzheimer’s Society, was worried that it could:

create perverse incentives to either admit people to long-term care too early, because perhaps there is a local authority incentive, or [...] incentivise people to keep the person with dementia at home far longer when actually it is not good for that person’s quality of life or for the family’s quality of life[.] ³⁴¹

286. Admitting people to residential care prematurely would, of course, run directly counter to the policy’s stated intention (and long-term DH policy) of making it possible for people to be cared for at home for as long as possible. Ms Owen, of ADASS, accepted that councils had a duty not to place people inappropriately in residential care; but they also had a duty to get value for money. If “the same sort of good quality care, can be provided at better value in residential care, you have a real dilemma” ³⁴².

287. Mr Bolton, from the DH, told us that this would be limited by lack of care home capacity, could be detected using councils’ spending returns and would be policed by the

338 Q 766

339 Q 608

340 Q 766

341 Q 609

342 Q 828

regulator (i.e. CQC).³⁴³ He thought there was “nothing particularly” that could prevent the operation of the opposite perverse incentives, for families to keep people out of residential care for too long.³⁴⁴ The Secretary of State also told us that the operation of the policy would be reviewed after 18 months to check for unintended consequences.³⁴⁵

Definition of personal care

288. The policy’s focus on the provision of personal care alone is also seen as problematic. Ms Owen referred to disputes in Scotland about demarcating the boundary between free personal care and other (means-tested) services:

the four activities of daily living I think could wrap us up forever in arguments about what does it mean. This is the experience of Scotland. Let us just take one example: Help with eating. What does it mean? Does it mean cutting up the food? Does it mean help with putting the food in your mouth? Does it mean microwaving it? Does it mean cooking it? For lawyers [...] this is going to be an absolute minefield.

She was also concerned at how the focus on personal care alone would fit with personalisation:

we have been spending the last two years working on personalising services, getting away from: “If you need this activity of daily living, then you need this” but having much more flexibility around the response. We must not throw out the personalisation of our services as we have to start looking at this.³⁴⁶

Paying for the policy

289. The most controversial aspect of free personal care at home is the question of paying for it. Sir Jeremy Beecham told us about the “new burdens doctrine”, whereby any new statutory duties imposed by central government on local government are fully funded, either by providing new money or lifting other obligations. In this case, he thought the Government had violated that principle.³⁴⁷

290. The Secretary of State insisted to the contrary:

The Department of Communities and Local Government does not consider this to be a new burden; it is part-funding and brings a lot of new money to the table for local government to build those services and help them achieve those savings. We see this as a partnership, not the dumping of a new burden.

He cited the Isle of Wight Council as an example of an authority that was already providing free personal care for all people aged over 80 who were being looked after at home, funded

343 Qq 46–53

344 Q 54

345 Q 901

346 Q 833; cf. Qq 766 and 821

347 Q 822

by efficiency savings, including reduced use of residential care. He thought that the Bill “very much nationalises the example of the Isle of Wight”.³⁴⁸

291. Sir Jeremy and Ms Owen both indicated that they doubted whether the Government’s estimates of the cost of implementing free personal care at home were “robust”, in respect of both the level of demand and unit costs. They suggested that the modelling work done for the policy could have understated:

- the cost of re-ablement relative to its benefits;
- possible increased demand from people who have hitherto been buying their own care;
- possible increased demand from people currently being looked after by carers;
- administrative costs.³⁴⁹

Sir Jeremy found the Government’s figures “suspiciously precise”³⁵⁰ and thought it might have been better to pilot the policy before going ahead with full implementation, to evaluate its cost properly.³⁵¹

292. According to the results of an ADASS survey, published in January 2010, the true cost of the policy could be at least £1 billion per annum, with the cost to local authorities reaching more than twice the £250 million stated by the Government. ADASS questions the Government’s assumption that personal care needs can be met through an average package of 6.54 hours of care per week at £15.75 per hour (amounting to £103 per week). It states that local authorities estimate a much more expensive average care package for a person with high needs, at an average cost of about £200 per week. In addition, the Association points out that the number of existing self-funders in any given area is often unknown, as well as the number eligible under the FACS criteria.³⁵²

Conclusions

293. We acknowledge that the Government is itself bringing forward significant interim reform of social care through the Free Personal Care at Home Bill. However, we have strong misgivings about this. The proposal for free personal care should be substantially increased, consistent with the introduction of a National Care Service.

294. For the Government suddenly to announce this new policy just weeks after publishing the Green Paper, and in the middle of the consultation period, smacks of policy-making on the hoof. The haste with which the proposals have been assembled is all too apparent in their shortcomings.

348 Qq 901 and 906. A recent press report has queried whether this policy is succeeding (“Free home care council diverting money from other vulnerable groups”, *Guardian*, 18 February 2010).

349 Q 826–827; cf. Q 608 [Mr Burke]

350 Q 835

351 Q 829

352 www.adass.org.uk/index.php?option=com_content&view=article&id=542&Itemid=361

295. Since only part of the social care system is to be changed, there is a risk of creating perverse incentives and introducing unanticipated consequences. Witnesses told us that families will have an incentive to try and keep people out of residential care longer than is appropriate, in order to continue receipt of free care. Councils, meanwhile, will have opposite incentives to place people in residential care prematurely, or to manipulate their eligibility criteria so that people being cared for at home are not classified as having higher levels of need.

296. Furthermore, estimates of the likely levels of demand and cost appear low, and there is a risk that the reform could be substantially underfunded. Local authorities have warned that they will not be able to fund their share of the costs from efficiency savings, as the Government intends. This could result in rationing or cuts in other services, including aspects of social care. Meanwhile, the DH has yet to make clear how exactly it will find its share of the funding. It has indicated that some will come from public health and research budgets, which could be detrimental to the long-term interests of NHS patients.

297. As we have stated, the option of a free social care system is one that needs to be debated and considered. However, it is not helpful for the Government to rush in a poorly thought-out and very circumscribed form of free care, as it is doing, rather than it being an integral part of a National Care Service.

“Fully national” or “part local/part national” system?

298. The Green Paper poses a choice between two models for the National Care Service, regardless of which funding option is ultimately chosen: a “part-national, part-local” system; and a “fully national” system.

299. Under the “part-national, part-local” option, people would be entitled to have their needs met, and a given proportion of their care and support package paid for by the state, wherever they lived. However, local authorities would decide how much to spend on each individual person’s package of care and support, giving councils flexibility to take into account local circumstances and costs, as well as the requirements of individual people.

300. There is certainly a case for a “localist” approach to social care. Geographical variations that are regarded as indicative of a “postcode lottery”, may in fact reflect different local circumstances, e.g. variations in cost or need for particular services or priorities. Where services are more limited in some areas than in others, it can be argued that this is balanced out by other things (for instance, lower Council Tax or more generous services of another kind). Sir Jeremy Beecham of the LGA told the Committee:

Sometimes I have been tempted to form a society for the preservation of the postcode lottery because I do think you have to respect local differences, not only in demand but how you meet that demand, and so you need a system which is flexible enough to allow you to engage with other partners, the third sector perhaps, in particular, to commission appropriately and to offer choice.³⁵³

301. Under the National Care Service’s “universal offer”, there would be a “portable” assessment, as we have noted. However, as Ms Norrish, of the DH, told us:

It does not necessarily mean that you get exactly the same services wherever you are, because if you are living in rural Devon you may actually need different services to those that you would need if you were living in the city of Durham [...]³⁵⁴

The prospect of there being no greater consistency between areas in respect of rationing and resource allocations does cause anxiety that the unfairness of the “postcode lottery” will simply be perpetuated under the new system. Sue Ryder Care told us:

if the Local Authorities retain control of the social care budgets and a National Assessment is introduced, both eligibility for services and the level at which they are delivered need to be portable.³⁵⁵

302. From this point of view, “localism” looks significantly less attractive than the “fully national” option. Under the latter, central government would set “the level of funding that people with a particular level of need and who need a particular outcome would receive”.³⁵⁶ The amount of funding allocated could be consistent across the country, or it could vary depending on location, to take account of the different costs of care across the country. Under this system, it is likely that all funding for care would be raised through national taxation, with councils not needing to raise funds locally through Council Tax.

303. In his evidence, the Secretary of State seemed to lean towards this option:

one can have national assessment and entitlement. Obviously, the question is: entitlement to what? That takes one into the question of how big one makes the offer. I agree with you. In recent times there has been a lot of fashionable talk about localism and giving people the ability to run things at local level. I believe that often the public do not want a postcode lottery certainly for healthcare but also social care; they want clarity about what they can expect and they want it to be fair across all areas. I believe that the case for national entitlement and assessment is very strong.³⁵⁷

304. Another issue is the question of integration of health and social care, for which our predecessor committee argued strongly in 2005.³⁵⁸ It can be argued that a “fully national” social care service might be more easily integrated with the “fully national” NHS.

Conclusions

305. Whether the National Care Service should be a national system locally provided (“fully national”) or a local system with national standards (“part local/part national”) is a key area of controversy. The argument in favour of local accountability, along with flexibility to meet local needs and priorities, is very persuasive. On the other hand, the

354 Q 15

355 Ev 109; cf. Ev 9, 6–7

356 Q 86

357 Q 877

358 Health Committee, Sixth Report of Session 2004–05, *NHS Continuing Care*, HC 399–I

“fully national” option would clearly be the best way to ensure more clarity and consistency in provision; it would also seem to be an effective means of bringing about full integration of health and social care. The lack of detail in the descriptions of the two options given in the Green Paper makes it difficult to arrive at a definitive view one way or the other. In particular, the Government must make clear whether the fully national option will involve a funding allocation mechanism that takes account of differing local costs.

Personalisation

306. Despite the universal consensus in favour of greater personalisation of care and support, the details of implementation are contentious in relation to issues such as fairness, equity and protecting vulnerable adults, as we consider below.

Individual Budgets or Personal Budgets?

307. Professor Glendinning, who led the IBSEN review, told us the Government was implementing Personal Budgets (involving social care funding only), rather than the more ambitious model of Individual Budgets (involving funding from a range of budgets):

The personal budgets that are now being implemented under Putting People First are social care resources only, and I do want to emphasise that this was probably the most disappointing element of the [IBSEN] pilots.³⁵⁹

I do not know the reason for the decision. The decision to roll out personal budgets across English adult social care was, of course, made before the findings of the IBSEN evaluation were available [...] My own personal view is that it was a political decision. I am not aware of any clear evidence underpinning that decision.³⁶⁰

308. There appears to be a widespread view that such a policy decision has been made.³⁶¹ However, this was denied by the Secretary of State and Hazel Hobbs, of the DWP:

Q942 Dr Taylor: Why have you given up on individual budgets which combined local authority social care money and other funding streams?

Andy Burnham: We certainly have not. Ms Hobbs may be able to say more about the right to control work that is going on for which DWP has legislated.

Q943 Dr Taylor: So, you have not given up on the idea?

Ms Hobbs: Certainly not. The principles running through and across government in this sense are about giving people the right to control, bringing together different funding streams, for which parliament legislated in the Welfare Reform Bill last year.

Ms Hobbs agreed there was some confusion of terminology.³⁶²

359 Q 780

360 Q 782

361 Ev 146

309. The Secretary of State emphasised that this approach was part of a fundamental shift that would occur across public services over the long term:

This is a very interesting side of public service reform that will play out not necessarily immediately but over the next 20 years. When you look at the effect of our health personal budgets pilot the intention is to merge it with direct payments in social care, employment and elsewhere, but here you cannot run before you can walk. The implications of all of this are pretty vast.³⁶³

Reform of disability benefits

310. One area where the DH appears keen to run ahead with combining budgets for care and support is the reform of disability benefits for older people by merging them into social care funding (an idea that was suggested by both Sir Derek Wanless and the JRF in 2006). However, this proposal has proved very controversial, illustrating some of the potential pitfalls of trying to combine different sources of funding in practice (something which was also a feature of the Individual Budgets pilots).

311. The two benefits concerned are Attendance Allowance (AA) and Disability Living Allowance (DLA), both of which are paid by the DWP. AA is a flat-rate, tax-free, non-means tested, non-contributory cash benefit for people aged 65 or over who need help with personal care. A person can receive AA regardless of whether they are receiving care and support. AA is intended to address “extra”, i.e. non-care, costs resulting from frailty or disability (such costs are many and varied—including special diets, incontinence pads, additional laundry, special clothes, extra heating, special bedding, extra lighting). However, it is entirely up to the recipient what they choose to spend the money on.

312. Council-sponsored care home residents are not eligible for AA after four weeks but the benefit is payable to self-funding residents. Many people living in their own homes who are entitled to AA do not receive local authority funded social care services, as they have Low or Moderate needs, which do not qualify for support under the eligibility criteria operated in their area.³⁶⁴ In such circumstances, AA is often used to help purchase services privately. For those people who meet local social care eligibility criteria, the benefit is used to help pay local authority social care charges.

313. There are two rates of AA;³⁶⁵ for 2009–10 they are £47.10 per week and £70.35 per week. At August 2009, 1.3 million people in England were in receipt of AA.³⁶⁶ DWP data show that in 2008–09, £3.9 billion was paid out in AA in England.³⁶⁷

362 Q 944. The Minister of State for Care Services, Phil Hope MP, has told the House: “The terms Individual Budget and Personal Budget were used synonymously during the pilot stage of the personalisation project. However, Personal Budget is the term now being used for national implementation and relates to social care funding only. Individual Budgets is now the term used for a notional amount of funding from a variety of sources which may include social care funding as well as other sources” (HC Deb, 18 January 2010, col 115W).

363 Q 945

364 Mr Wittenberg, of the PSSRU, told us:

An analysis that colleagues did of the data set known as ELSA [...] found that only 26% of the Attendance Allowance group received social care, either publicly or privately funded, and that 29% of the Attendance Allowance people received neither formal nor informal care (Q 213).

365 The lower rate of AA is payable if the recipient needs help with personal care frequently or supervision continually throughout the day only, help with personal care or someone to watch over them during the night only, or someone to be with them when they are on dialysis. The higher rate is payable if the recipient needs help with

314. DLA provides a weekly fixed sum for the purpose of assisting a claimant with the extra costs associated with disability. As with AA, it is non-means-tested, non-contributory and tax-free. DLA is made up of a mobility component and a care component. The mobility component (for help with walking difficulties) is paid at two different levels. The care component (for help with personal care needs) is paid at three levels. A person can receive a care component along with a mobility component. Although DLA can be paid indefinitely, there is an upper age limit for making the first claim. Claims must be made before a person's 65th birthday. Otherwise, AA may be claimed instead. AA has no mobility component, but the disability tests are the same as for the middle and higher rate care components of DLA (this means that someone who qualifies for the lower rate of DLA will not qualify for receipt of AA).

315. In 2009–10, the three weekly DLA care component rates are £18.65, £47.10 and £70.35; the mobility component rates are £18.65 and £49.10. At August 2009, 634,000 people in England aged 65 or over were in receipt of DLA. The amount paid in DLA to people aged 65 or over in England in 2008–09 was £2.6 billion.³⁶⁸

316. Following the publication of the Green Paper, it appeared that the Government was planning to reform DLA paid to people under 65, but, in the face of much concern over the potential loss of this benefit, it was eventually clarified that this was not the case.³⁶⁹

317. We heard that the Government's case for reform rests on its view that AA and DLA, as non-means tested benefits, are ill-targeted and the sums involved could be better used. Ms Norrish, of the DH, told us that "the vast majority of people who get AA need it, they are on low incomes and they have high levels of need". However, the Government believes that significant amounts of money are being paid to wealthy older people with little disability, as Ms Norrish told us:

I have had people coming up to me telling me stories about people they know who get their AA and put it in the bank and are keeping it "to pass on to their grandchildren". There was one person I heard about who every year goes on a four-week Saga cruise and uses her AA to extend it to a six-week cruise. This is where we have to take a view on whether the best use is being made of public funding. The judgment that we took around that was that you could transfer that funding from the people who are on higher levels of incomes to people who are on lower incomes and who potentially have higher levels of need and so that is the proposal in the Green Paper.³⁷⁰

318. However, in our evidence we also heard strong opposition to the reform of disability benefits; and even those who support the idea in principle (seeing the benefits of combining disparate streams of funding) have concerns about implementation.

personal care, or someone to supervise or watch over them frequently throughout the day and also during the night.

366 statistics.dwp.gov.uk/asd/tabtool.asp

367 Department for Work and Pensions, Benefit Expenditure by Country, Region and Local Authority 2008–09

368 Provisional data supplied by the Department for Work and Pensions

369 HC Deb, 30 November 2009, 527W; www.dh.gov.uk/en/News/Speeches/DH_107455

370 Q 70

319. Ms Norrish’s assertion that AA was being spent on Saga cruises prompted Mr Harrop, of Age Concern and Help the Aged, to warn: “I think we are in danger of policy-making by anecdote”.³⁷¹ This is confirmed by research which has been done by Professor Ruth Hancock, of the University of East Anglia, and her colleagues. This found that disability benefits are more likely to be claimed by “People with higher levels of age and disability, and lower levels of income”, with the benefits “display[ing] a degree of income targeting”, because less well off people are more likely to have a disability and to claim. The group also found “no evidence” of significant numbers of people receiving the benefits “without any accompanying health problem”.³⁷²

320. The key objection to the reform of disability benefits is that many people with genuine care and support needs, and only modest means, will be left worse off. The Green Paper states that:

people receiving any of the relevant benefits at the time of reform would continue to receive an equivalent level of support and protection under a new and better care and support system³⁷³

321. Ms Norrish and the Secretary of State emphasised that there would be transitional arrangements to ensure that there were “no cash losers”³⁷⁴ among current recipients of disability benefits in the event of reform. However, there remain concerns that people who develop a care and support need in future could be worse off than they would have been under the current system. While the Secretary of State refused to be drawn on this, saying he did not wish “to second-guess the White Paper”,³⁷⁵ Ms Norrish was more forthcoming and admitted that “yes, some people would be nominal losers”.³⁷⁶

322. Critics of reform told us that:

- effectively means-testing disability benefits would mean “People on the threshold of means tested care and support funding will lose out to the greatest degree”,³⁷⁷ due to the “cliff edge” effect that is inherent in current social care means-testing;
- disability benefits support prevention by helping people, especially those with low-level needs, to remain independent for as long as possible,³⁷⁸ in contrast to social care, which currently does very little for people with low-level needs;
- carers could be adversely affected, since disability benefits are “carer blind”, whereas social care very often is not;³⁷⁹

371 Q 620

372 SC 52

373 Department of Health, *Shaping the Future of Care Together*, Cm 7673, 2009, p 15

374 Qq 71, 935

375 Q 936

376 Q 71

377 Ev 30

378 Ev 131

379 Qq 621, 623

- people who use disability benefits to pay for “extra costs” (their intended purpose) will lose out, as social care services will not pay for these, which could particularly affect people with mental health problems, people with MS and cancer patients, among others;³⁸⁰
- disability benefits act as “passports” to other benefits, including Carer’s Allowance, so being unable to access cash support as a consequence of reform could have knock-on financial consequences;³⁸¹
- there is an apparent contradiction between the Government’s support for personalisation and potentially excluding some people from receiving benefits that are described as “the perfect direct payment”³⁸² and “the original personal budget”;³⁸³
- applying for disability benefits involves a simple paper-based, self-assessment process and replacing this with something akin to the “administratively bureaucratic”³⁸⁴ social care assessment could dissuade people from applying;³⁸⁵
- reforming disability benefits only for older people will lead to age discrimination, since someone could become significantly worse off simply by virtue of turning 65 as a result of the type of reform proposed.³⁸⁶

323. All of these points, ultimately, stem from uncertainty about key aspects of the National Care Service: the nature of the funding system; what kind of means-testing will operate; how working-age adults will be affected; how people will be assessed; to what degree rationing will operate; and the extent and value of the care packages that will be available. Mr Hirsch pointed out to us:

the illustrative costings that are being used in the Green Paper are really based on what is being spent now within the care system. They say it would cost £30,000 roughly over somebody’s life to fund their likely care from age 65. I think it is likely to be more than that if you bring in these extra needs [currently being met through disability benefits].³⁸⁷

324. Age Concern and Help the Aged told us they would not object to reform of disability benefits if all the advantages of AA and DLA could be preserved in the National Care Service,³⁸⁸ but the Green Paper says nothing to guarantee that will be the case. As we have

380 Ev 73, 113, 131; Qq 730, 731

381 Qq 627, 927

382 Ev 56

383 Ev 77; Q 620

384 Q 623. The Secretary of State told us the Government intended to develop an “integrated assessment that takes stuff from the benefits side and the local authority side” (Q 929).

385 Ev 133; Q 621. There is already said to be significant underclaiming of disability benefits, particularly among the very old.

386 Q 627; Ev 115. The Government insists that there is no age discrimination in treating DLA for people aged under 65 differently from disability benefits for older people. Ms Norrish told us that “people who are receiving DLA under 65 are almost exclusively on very low incomes”, being “frequently [...] unable to work”, and so without assets, whereas disabled people aged over 65 “potentially have worked all of their lives” (Q 72–73; cf. Q 931).

387 Q 295

388 Ev 115; Q 624. Twenty-six per cent of people polled by the Parkinson’s Disease Society said they “would be happy for AA to be abolished if all their disability-related costs were met” (SC19A).

noted, uncertainty about winners and losers under the National Care Service leaves scope for some to suggest that “progressive universalism” for many people will be just “smoke and mirrors”, since they will lose at least as much as they will gain.

Funding levels

325. We heard in our evidence that it is particularly important for the success of personalisation that the value of the care packages available under the National Care Service should be adequate to meet people’s needs and not perpetuate existing shortcomings, such as age discrimination.³⁸⁹

326. These existing problems could also be compounded under personalisation. Mencap told us about its concern:

that some local authorities will use individual budgets [...] to save money. It is widely thought that individual budgets are cheaper than the traditional service provision and could be used to reduce local authority spending.³⁹⁰

UNISON said it:

would like to see a guarantee that Direct Payments and Individual Budgets will be updated each year to reflect rising costs so they maintain their real value. Currently some local authorities do not have any agreed indexing of rates, leaving it to individuals to seek to negotiate uplifts.³⁹¹

327. We also heard that Resource Allocation Systems need to be flexible in order to capture appropriately individual people’s needs and ensure adequate funding is made available to meet them. Sense, the deafblind charity, told us this was a “crucial point for deafblind people who often have specialist and therefore more expensive to meet needs”.³⁹²

Choosing to keep mainstream services

328. UNISON told us that some people were actually experiencing less choice as a result of councils “claiming that the introduction of Direct Payments is forcing them to close day care centres”,³⁹³ since Direct Payments cannot under current law be spent on council-provided services. The union’s witness, Mr Low, further told us: “we are getting daily reports of local authorities seeking to close day care centres, and they are saying it is because of the growth of personal budgets”.³⁹⁴

329. Professor Beresford explained why the right to choose such collective services should not be withdrawn in the name of personalisation:

389 Ev 114; cf. Ev 59

390 Ev 7; cf. Qq 102, 776

391 Ev 80

392 Ev 10

393 Ev 80

394 Q 365

mental health service users are seriously concerned about the disinvestment / closure of day services. There have been day services, day centres for mental health service users and people with learning difficulties that have not been good [...] but what they can be (and some are) is places where people can feel safe, have relationships, get support and have a springboard to other things [...] people say, “It is not often safe outside. If I behave in a way or am seen to be different or weird, people may not be nice to me. I like to be somewhere where it is not like that [...] I would like to go somewhere where I can feel reassured.”³⁹⁵

UNISON suggested that:

certain local authority services need to be ring fenced to protect and guarantee local well run services as a sustainable choice for people wanting a Personal Budget and not a Direct Payment. Direct Payment holders should be free to purchase local authority services if they wish.³⁹⁶

John Waters, of In Control, thought that maintaining collective services for some people had to be balanced against people’s right to “vote with their feet” and choose other services.³⁹⁷ Professor Beresford emphasised the importance of “User-controlled services, user-controlled organisations” and was concerned that, for all the talk of “plurality of supply”, this approach was still insufficiently supported.³⁹⁸

Information, advice, advocacy and brokerage

330. We heard from Professor Beresford that for Direct Payments to be truly empowering much more was needed than simply the ability to make cash transactions:

We know that the group of people who do that routinely—self-funders—is the group most vulnerable, often unnecessarily, to institutionalisation, to moving into residential services. It was intended as a shift in power, and I think a lot needs to be in place [...]: the idea of a system of infrastructural support, advice, guidance, of local organisations of service users, neither of which is truly in place, both of which have financial implications.³⁹⁹

He cautioned that purchasing care and support “is not the same as buying a fridge or going on holiday”.⁴⁰⁰

331. The lack of funding to allow people to access information, advice, advocacy and brokerage in forms appropriate to their needs is seen as a significant obstacle to self-directed support. We heard that it is vital for such services to be available in appropriate forms and to be adequately funded, so that people are not obliged to fund them from the budget allocated for their care and support; and support must be available on a continuing

395 Q 788

396 Ev 80; cf. Ev 122

397 Q 789

398 Qq 789 and 790

399 Q 783

400 Q 792

basis. This could be a role for local authority social workers, although there is an argument for such services to be commissioned from independent providers such as the voluntary sector. While some caution against “over-professionalising” the brokerage role (suggesting that it could be fulfilled through “peer support”, for instance), others argue that it does entail a definite set of skills and requires some form of qualification.⁴⁰¹

Market management

332. Witnesses informed us that personalisation could have a major effect on the social care provider market, with a shift away from local authority block contracts and towards commissioning on an individual basis. Mr Jerome, the National Director for Social Care Transformation, told us:

A decision needs to be made about what councils need to collectively commission [...] and what they might be passing over to individuals for them to access the market. The council role therefore is to make sure in discussion with suppliers—and there is a big issue for suppliers here—that those services that people want are there.⁴⁰²

333. Independent providers could find their services affected by these changes just as much as council services. According to Nestor Healthcare Plc-Social Care Division:

In areas such as Extra Care Housing where service users choose to move into housing where care is provided on site 24 hours per day, the impact of Local Authorities introducing direct payments for individuals within a scheme could serve to destabilise a service.⁴⁰³

The UK Homecare Association feared major destabilisation of the homecare sector, with homecare workers being “poached” and employed as PAs, and low resource allocations driving prices down even further. There is even, the Association feared, the possibility of “large-scale destruction of the sector”, leading to an overall reduction in capacity.⁴⁰⁴

334. These predictions may be somewhat exaggerated, but it seems likely that local authorities could face significant challenges in their new role as strategic market managers. There will also be particular local issues that could be difficult to address. For instance, Professor Anthea Tinker, of King’s College London, informed us that research indicated “local care markets may be historically under-developed in more remote rural locations”.⁴⁰⁵

401 Ev 8, 10, 11, 72, 74, 80–81, 90, 91, 94, 108, 109, 114, 116, 117, 121, 132, 145, 146, 147; Qq 372, 394, 667–669, 672, 733–734, 741, 776, 791, 860–865

402 Q 113

403 Ev 35

404 Ev 52, 54, 55

405 Ev 156

Protection and risk

Protecting vulnerable adults

335. The nature of care and support (providing intimate help to vulnerable people, often on a one-to-one basis in their own home) mean that there can be a risk of abuse or exploitation. In 2000, the DH and the Home Office published *No secrets*, requiring local councils with social services responsibilities, NHS bodies and other partners to develop local multi-agency codes of practice to help prevent and tackle abuse of children and vulnerable adults. In a consultation document in 2008, *Safeguarding Adults: A Consultation on the Review of the 'No Secrets' Guidance*, the Government recognised potential tensions between protecting vulnerable adults and the personalisation of social care.

336. In 2004 the DH launched the Protection of Vulnerable Adults (POVA) scheme, whereby prospective care workers could be checked, as part of Criminal Records Bureau (CRB) Disclosure, against a list of care workers who had harmed vulnerable adults in their care. This was mandatory in respect of adult placement schemes, domiciliary care agencies and care homes. People employing PAs using Direct Payments were not required to obtain CRB Disclosure, but had the option to request it. In October 2009 the POVA list became the Adults Barred List and the scheme was replaced by Adult First Check, both operated by the Independent Safeguarding Authority (ISA), a new non-departmental public body.

337. From July 2010 a completely new system will be implemented. All individuals in England, Wales and Northern Ireland working or volunteering with vulnerable adults or children in the education, care and health sectors will be required to register with ISA under the new Vetting and Barring Scheme (VBS). Individuals will be required to pay £64 to be registered with ISA in England. The VBS will apply to homecare workers, but not to PAs.

338. In 2008 Skills for Care found that “48% of people receiving direct payments failed to make CRB checks on their PAs whilst 46% failed to seek references”.⁴⁰⁶

339. A survey of social workers in adult social care published in October 2008 found that nine out of ten respondents favoured mandatory CRB Disclosure for PAs and others hired using Direct Payments.⁴⁰⁷

340. Independent sector providers were unhappy with the different standards applied to their staff as compared to PAs in this respect. According to Nestor Healthcare Plc-Social Care Division:

With the advent of the vetting and barring, system for domiciliary organisations there is potential for careworkers wishing to avoid the ISA processes to migrate into personal assistant roles. In rural areas where the recruitment of personal assistants may be more difficult and the role of PAs is undertaken by family members unregulated support again poses the risk of abuse with research indicating in cases of

406 Ev 36

407 “Nearly all adult social workers want personal assistants to be regulated”, *Community Care*, 23 October 2008

elder abuse two thirds of incidents are perpetrated by relatives, most often the individual[']s adult child or spouse.⁴⁰⁸

341. However, others who raised this issue argued that it would not be in keeping with the spirit of self-directed support to require people employing PAs to subject them to formal vetting. UNISON and CQC both echoed the view of CSCI that local authorities could discharge their duty of care by ensuring that all people employing PAs were informed of their right to seek a CRB (or, in future, ISA) check if they wished to.⁴⁰⁹

342. We also heard that personalisation can raise issues about the welfare of carers. The Princess Royal Trust for Carers said that, in the case of Individual Budgets:

There is [...] evidence that the responsibility for managing and co-ordinating the budget holder's support arrangements falls to the carer at the risk of experiencing increased stress.⁴¹⁰

Workforce regulation

343. In 1997 the Labour Party manifesto promised that a Labour government would ensure that the entire social care workforce (around 1.4 million people) would, over time, be subject to regulation. The General Social Care Council (GSCC) was set up in 2001 under the Care Standards Act 2000. The GSCC was initially given the task of registering and regulating social workers (who number some 80,000) and social work students (of whom there are approximately 16,000). It was anticipated that regulation would be progressively extended to the entire social care workforce, with the next groups to register being homecare workers and their managers (numbering about 500,000).

344. In 2004 our predecessor committee recommended in a report on elder abuse that:

when the General Social Care Council opens the register to domiciliary care workers it should also ensure that care workers who are employed through direct payments are also able to register should they wish to do so, and indeed should be so encouraged. We anticipate that over time this would lead to many such personal assistants choosing to register because of the advantage that it would offer in demonstrating their competence and reliability to a prospective employer.⁴¹¹

345. In April 2009 the GSCC was given the go-ahead to open the register for homecare staff in England (initially on a voluntary basis) in early 2010.⁴¹² The Council also planned to consult on options for possible regulation of PAs. However, the Government has, for the time being at least, indicated that the GSCC will operate solely as the professional regulator

408 Ev 36; cf. Ev 55

409 Ev 81,83; Qq 369–371

410 Ev 121

411 Health Committee, Second Report of Session 2003–04, *Elder Abuse*, HC 111–I, para 152

412 Department of Health, *Working to Put People First: The Strategy for the Adult Social Care Workforce in England*, April 2009

for social workers. Questions about whether and how regulatory models for other parts of the social care workforce will develop have still to be addressed.⁴¹³

346. In 2008 Skills for Care published research showing that people using Direct Payments to employ PAs were in favour of a formal register but evenly divided on whether registration should be compulsory.⁴¹⁴

347. Independent sector providers informed us that they found it irksome that (as with vetting) there was not consistency between them and the PA market. The UK Homecare Association took the view that:

It seems entirely illogical that government should have brought about a highly regulated sector [...], with proposals for further regulating by the General Social Care Council (GSCC) [...] while at the same time, promoting a cash payment system for the engagement of untrained, unqualified, unsupported and unregulated personal assistants⁴¹⁵

Nestor Healthcare Plc-Social Care Division argued that “Regulation of personal assistants needs to be considered.”⁴¹⁶

348. Mr Low, from UNISON, told us that the union was more open to the idea of compulsory registration of PAs than it was to compulsory vetting. He told us:

At the moment, I believe [...] the General Social Care Council are not currently going to proceed with pushing registration into domiciliary care. If they had done, we would have felt that they should have also done personal assistants too, to create a level playing field.⁴¹⁷

349. The union thought that one helpful way to give people choice whilst avoiding some of the pitfalls of an unregulated workforce was for councils to take on “banks” of PAs. Another was the implementation of a model code of practice on the employment of PAs.⁴¹⁸

350. SCIE acknowledged there were concerns about:

the emergence of unregulated ‘grey’ markets, the effects of migrant labour, quality assurance and employment and training conditions.

However, it seemed to have no clear view on whether or not further regulation was needed:

413 The extension of registration was one issue examined in 2009 by the Council for Healthcare Regulatory Excellence in a report commissioned by the DH as a result of concerns about the backlog of conduct cases built up by the GSCC. The report recommended consideration of other approaches in respect of domiciliary care workers “such as a statutory licensing scheme or an employer-led approach based on codes of conduct and practice and induction standards” (Council for Healthcare Regulatory Excellence, *Report and Recommendations to the Secretary of State for Health on the conduct function of the General Social Care Council*, September 2009, para 8.28).

414 Q 405; www.scie.org.uk/publications/atagance/atagance14.asp

415 Ev 55

416 Ev 34

417 Ev 363

418 Ev 81; Q 362

These concerns need to be discussed with people employing and planning to employ PAs, representatives of PAs who are becoming a significant part of the social care workforce, and the workforce and service regulators who will need to consider new approaches to regulation that fit the new diversified world of personalisation.⁴¹⁹

351. Professor Beresford warned that formal registration or regulation (or vetting) could give people employing PAs “a false sense of security” and quoted one employer’s comment that “What really works for me is my gut feeling about [a prospective PA] as a human being”. Professor Beresford did not, though, rule out establishing some kind of registration or regulation, in association with employers, once the PA role had had time to develop and become established.⁴²⁰

Conclusions

352. **Although there is effectively unanimous agreement in principle with personalising care and support, the pace of change remains slow. However, “transformation” promises to take social care into uncharted waters and the profound ramifications, and risks, of this need to be fully considered and worked through.**

353. **There has been confusion about whether the Government is pressing ahead with Individual Budgets (combining various funding streams in addition to social care moneys) or instead adopting the less ambitious model of Personal Budgets (involving social care funding only). The policy, and the associated terminology, must be made absolutely clear, as well as the basis for whatever decisions are taken.**

354. **The Secretary of State told us that personalising social care is part of an aspiration to remodel drastically all public services “over the next 20 years” and the “implications of all of this are pretty vast”. The Government appears to have a goal of bringing together all disability-related expenditure while giving individual disabled people control of all the sums available to them, so they are better able to use them to meet their particular needs. There is a logic to this, but it will raise some contentious and difficult issues. For instance, personal health budgets, which are currently being piloted in the NHS, raise the thorny questions of top-ups and vouchers (on which basis the Government itself ruled out individual budgets for healthcare as recently as 2006).**

355. **The idea of reforming disability benefits for older people (Attendance Allowance and Disability Living Allowance) by merging the budget for these into social care funding has been particularly controversial. Many of the concerns that have been expressed about the likely consequences of this demand careful attention. It is feared that some people would be left worse off if universal, needs-based and entitlement-led social security benefits are replaced with means-tested, rationed and cash-limited social care provision. The Government has given assurances that there would be “no cash losers” under transitional guarantees for existing benefit recipients. However, no such guarantees would apparently extend to people who develop a care need in future, who**

419 Ev 147

420 Qq 796, 797

could be worse off under a new system than they would have been under the current one.

356. In justifying this proposal, the DH told us about wealthy claimants allegedly using AA payments to fund Saga cruises. We believe this kind of “policy-making by anecdote” is not helpful and risks disparaging people who have genuine care and support needs. Research by Professor Ruth Hancock and her colleagues indicates that disability benefits are a lifeline to many people, with significant needs and without great wealth, who often don’t receive help from the social care system, enabling them to meet costs of daily living. If the DH has hard evidence to the contrary, it should be published. We also note that there appears to be a tension, if not a contradiction, in the Government’s policy in that, while it says it is committed to more universalism in care and support, in this case it appears to be intent on going in the opposite direction.

357. Adequate funding is clearly vital to personalisation, which must not be seen as a cost-saving exercise; it may well cost more to provide adequate personalised care and support. Some people in receipt of Direct Payments have found that inadequate funding and inflexible Resource Allocation Systems make it difficult for them to meet their needs without topping up from their own resources. Personalisation must not mean that people who use services are simply turned into rationers of their own care and support, having to make choices which compromise their ability to meet their needs or to maintain their dignity.

358. It must be recognised that not every person who uses social care services will want to take on an entrepreneurial and managerial role as commissioner of their own care and support. Nor should it be assumed that taking on such a role is the only means by which people can be empowered and made full partners in their own care. The potential of “co-production” (i.e. full partnership between providers and people who use services) to allow personalisation of mainstream services, including residential care, should be fully explored within the “transformation” agenda.

359. There are concerns about the right of people who use services such as day care centres to continue doing so, if that is their preference. Such services should not simply be shut down with people being told that it is now down to them to act as commissioners. In some cases it may be appropriate to “ringfence” services for those people who wish to continue using them, although this should not be an excuse to protect outmoded and poor quality services.

360. Where people do act as their own commissioners, information, advice, advocacy and brokerage services must be available and must not be funded from people’s own resource allocations. Offloading such responsibilities and costs onto people who use services could seriously curtail or negate the potential benefits of personalisation.

361. People commissioning their own services in some areas may find that the market fails and they are unable to procure the care and support they need, particularly in rural areas. It is not certain that councils will necessarily have the capacity or the capability to act as effective market managers in such situations.

362. Personalisation necessarily entails enabling people who use services to take risks on their own behalf, as part of assuming control of their own care and support.

However, there are contentious issues concerning the nature and extent of such “risk transfer”. Adult-protection and safeguarding policies (consistent with councils’ duty of care) must be tailored to situations where people are directing their own care and support. Many people will be comfortable with managing risks themselves and should be free to do so, but it is imperative that others are able to access appropriate safeguarding mechanisms. The risk of placing unreasonable demands on carers, either as care providers or as care managers, must also be acknowledged and considered.

363. There are fears about the possible emergence of an unskilled, casualised, unregulated, and potentially exploited, workforce of Personal Assistants (PAs) operating in a semi-informal “grey” market. Local authority “banks” of PAs, which people may choose to commission from if they wish, may be one way of addressing such concerns. There seems to be agreement that people employing PAs should always be given the option of running Criminal Records Bureau checks on prospective employees. Beyond this, however, there are differing views on whether PAs should be subject to mandatory regulation and obliged to register with the Independent Safeguarding Authority under the new Vetting and Barring System. Without a “level playing field” in regulation between PAs and social care staff employed by councils and others, unsuitable staff could migrate from regulated sectors into unregulated PA roles. Nonetheless, many people who employ PAs will insist that they should be free to choose who they wish to work for them. There should be a regulated option for those who wish to use this route, but people who prefer not to use it, and give informed consent to accept the risks that may arise, should be free to do so. Strong safeguards must, though, be put in place to protect the vulnerable.

The social care workforce

364. The social care workforce has begun to change significantly, and is likely to change much more, particularly as a result of personalisation. This is reflected in several strands of DH policy.

365. In 2003, the DH commissioned Skills for Care to undertake work to identify new roles in social care. The New Types of Worker project has shed important light on how the social care workforce is changing as new modes of care and support develop, with “about 14 new kinds of jobs” being found in social care.⁴²¹ Skills for Care has identified that a disproportionately high number of social care workers have difficulty with basic skills, including reading, writing and simple maths. One way it is addressing gaps in social care workers’ skills is through developing a National Skills Academy.⁴²²

366. In April 2009, the DH published *Working to Put People First: The Strategy for the Adult Social Care Workforce in England*. This only sketched out priorities for the development of the workforce in the context of personalisation and left much detail to be filled in on key issues, notably: training and career pathways for PAs; and the future role of social workers.

421 Ev 139, 163; Q 400

422 Ev 383, 784, 797

367. Lin Hinnigan, Director of Strategy at the GSCC, told us there needed to be funding available to help with the training of PAs, but she pointed out that it would be contrary to the idea of personalisation to try and oblige people to have their PAs trained:

Do you start to impose upon them, “Your partner must have this particular sort of training”? The person who is employing that person may say, “Their knowledge and their learning has been learning about my needs and me and how best to meet them”. They are very complex questions to try and set out what are the requirements. We need to unpack this, but we will need to move to certain standards and have the ability for people as part of their choice to say, “I don’t want to take those standards”.⁴²³

368. The future of social work is under active consideration at the moment. In December 2008, the DH and the Department for Children Schools and Families established the Social Work Task Force to conduct a “nuts and bolts” review of the profession and to advise on the shape and content of a comprehensive reform programme. This was done on the grounds that social work is facing some acute challenges and concerns, including the quality of initial training, recruitment and vacancy rates, and the status of the profession as a whole. The Task Force reported in December 2009, recommending a series of measures to be implemented through a single national reform programme for social work.

369. The GSCC envisages social workers “tak[ing] on the new roles aimed at supporting people to design their own care packages” as social care becomes more personalised. However, there are differing views as to whether social workers will still have a significant role to play in social care once personalisation really takes hold.⁴²⁴

Conclusions

370. It is clear that the social care workforce as a whole is increasingly in a state of flux, with existing roles changing and others emerging as new models of care and support provision develop. The role of social workers in particular in a radically changed social care system is still unclear, with contending views being expressed. Plans to extend regulation to the rest of the social care workforce now seem to be in disarray. We are concerned at what appears to be the apparent lack of an overarching strategic vision for the future social care workforce, and we recommend that this be addressed as part of social care reform.

423 Q 405

424 Ev 163

7 The way forward

371. While there is welcome consensus on several aspects of social care reform, a number of key issues remain highly contentious and insufficiently addressed. Many witnesses agreed that worthwhile and lasting reform will only be achieved if consensus can be reached on these issues too, so that the necessary tough decisions can be taken with broad popular support.

372. Achieving consensus on all these difficult and enduring issues requires calm, rational deliberation and an informed national debate. We would have liked to see all the political parties come together in that spirit to map out a programme of sustainable reform. Instead, regrettably, the Government is hastily drafting a White Paper while also rushing through Parliament a hurriedly concocted Bill that cuts across its own Green Paper, in a febrile atmosphere of unedifying pre-election party-political squabbling and point-scoring.

373. There is still an opportunity, in advance of the demographic challenges to come with the ageing of the “baby boomers”, to reform the social care system, achieving consensus and creating a lasting solution that would represent a “Beveridge” model for our time. Current and future generations will be betrayed if the failure to achieve consensus means that social care reform is once more left to languish near the bottom of Government’s list of priorities in the next Parliament.

Conclusions and recommendations

Meeting future demand and costs

1. A compelling argument for thoroughly reforming the social care system is that in its current form it will struggle to meet people's needs under the pressure of future growth in demand and costs. However, we recognise that anticipating these is a far from exact science and there is much uncertainty. Projections are made from observed trends, based on a series of plausible assumptions about a number of variables, but within a considerable "funnel of doubt", which expands into the future. (Paragraph 69)
2. In order to minimise that doubt, the best possible evidence base is needed. We are, therefore, extremely disappointed that, fourteen years after our predecessor committee called on the then Government to commission better data on healthy life expectancy, the delay in doing so means the available data are still inconclusive. The Cognitive Function and Ageing Study and the English Longitudinal Study of Ageing are expected in due course to yield cohort data and we recommend that the DH take full account of these as soon as they become available. (Paragraph 70)
3. Despite the degree of uncertainty about future demand and cost, it is nonetheless clear that, on all reasonable assumptions, the social care system will face considerable increased pressures in the decades to come. It is important, though, to avoid demographic despair and alarmism. Population ageing is far from being a new phenomenon, nor is it unique to this country. Its effects have not yet proved catastrophic and there is no compelling reason to suppose that they will in the future, provided the right political decisions are made now. (Paragraph 71)
4. We note that, in its presentation of the data on life expectancy, the DH has confused period and cohort measures of life expectancy, as well as life expectancy at birth and at age 65. In so doing, there is a danger of overstating the extent of demographic change and potentially discrediting the projections used. In an area that is characterised by uncertainty, it is essential that care is taken to interpret existing data accurately. (Paragraph 72)
5. The Department has also not made clear that part of the demographic challenge facing the social care system is the transient "cohort effect" of the ageing of the population "bulge" born during the post-war "baby boom". The fact that the first "baby boomers" will not enter their mid-80s until the early 2030s means that there is still a 20-year "window of opportunity" in which to prepare for this. This is not an argument for complacency, far from it; but there is a chance to address the challenge systematically so as to ensure comprehensive and lasting reform, rather than being led by panic into further incremental reform of marginal and temporary value. (Paragraph 73)
6. We are concerned that an ageing population is too often seen in public debate as something negative, a problem to be solved, with older people regarded as a burden. The fact that many more people can expect to live well into old age is one of society's

greatest achievements and something to be celebrated rather than lamented. (Paragraph 74)

7. Longer life expectancy does not inevitably mean more years lived with ill health and disability; people can live lives that are healthier as well as longer, and many older people are living proof of this. Future healthy life expectancy is not fixed; actions taken now could help to make the “compression of morbidity” more likely. The importance of research to develop curative or mitigating interventions for long-term conditions should not be underestimated. Such research could pay major dividends, in terms of health outcomes and public spending, as well as in individuals’ quality of life, and must be adequately supported and funded. Similarly, the importance of public health interventions must be acknowledged. The health risks posed by smoking, drinking, poor diet and lack of exercise have important implications for future social care demand. This reinforces the need for interventions to address these issues, although their effectiveness must be rigorously evaluated. It also reinforces the importance of coordinating health and social care services. (Paragraph 75)
8. We would also counsel against pessimism regarding the affordability of care and support in the future. The old-age “support ratio” or “dependency ratio” is not the most important factor to take account of in determining the likely future affordability of social care. Our society must not underestimate its ability to become more productive and wealthier, nor indeed the contribution that the growing numbers of older people will continue to make to that. (Paragraph 76)

Shortcomings of the present social care system

9. The multiple shortcomings of the existing social care system provide powerful arguments for fundamental reform. Too often when people approach the system for help they do not receive even information and advice on what is available and how to access it. The system is also often poorly co-ordinated with other help (not least NHS services and care provided voluntarily, as well as the housing support and social security benefits systems). People who need care and support encounter various forms of rationing, including by eligibility criteria, means-testing and charging, with much local variation. Where people are able to access care, it can be insufficiently focused on helping them to remain independent and avoid developing greater needs, as well as being limited in scope and not always of good quality. In these respects too, there is marked variation between local areas. The result is a social care system that:
 - excludes many people with less severe care needs;
 - penalises people with relatively modest financial means;
 - places unfair and unreasonable demands on carers; and
 - varies geographically to an extent that is strongly perceived as unfair.

In consequence of all these factors, there is a great deal of unmet need. (Paragraph 157)

10. These shortcomings are all indicative of a system that: provides a residual or “safety net” service, rather than a universal one; is chronically underfunded; and is insufficiently focused on the needs and aspirations of the individual people who actually need care and support. (Paragraph 158)
11. On the particular issue of quality, we note that the effectiveness of regulatory systems in uncovering and addressing poor quality care is an issue. (Paragraph 159)
12. We have also concluded that more needs to be known about the role of particular factors in compromising standards. The staffing issues that we heard about (lack of training and career-development, inadequate staffing levels and high staff turnover), and their relationship to low pay levels, need to be investigated fully. The apparent quality “gradient” between for-profit and non-profit providers of care services is also of concern and this too needs to be fully examined. (Paragraph 160)
13. Pervading the whole system of social care is a persistent ageism, both overt and covert. We welcome the fact that the Government and the Equality and Human Rights Commission have finally recognised this and begun to address it but we are appalled that this has taken so long. (Paragraph 161)

Plans for reform

14. Social care reform has two interrelated strands: the first concerned with how care and support are funded and the second with how they are commissioned and provided. When the Government took office in 1997, it stated that the first of these was one of its major priorities. Yet it took until 2009 for the Government to set out a range of options for fundamental reform, in the Green Paper *Shaping the Future of Care Together*. This came so late in the present Parliament that the White Paper containing the Government’s plans for change will be published just weeks before a general election, with no prospect of legislation until the next Parliament. The problems, and the options for solving funding reform, have long been known; and prime opportunities to initiate reform (a Royal Commission in 1999 and major reform proposals resulting from independent reviews) have been squandered. The failure to grasp this nettle is sadly indicative of the low priority given to social care by successive administrations and this must not continue. (Paragraph 221)
15. On the second strand of reform, how care and support are commissioned and provided, the Government has made better use of its time in office, initiating a programme of “transformation” with potentially far-reaching consequences. We strongly welcome the focus on personalisation as the way forward, although we recognise that there is still a long way to go before all councils are offering genuinely self-directed support. (Paragraph 222)
16. The Green Paper *Shaping the Future of Care Together* sets out the Government’s vision for a National Care Service, embodying both strands of reform. The following major elements of this vision have attracted practically universal consensus and we too strongly endorse them:
 - A focus on prevention, rehabilitation and re-ablement;

- A “portable” national assessment, backed up by national uniformity in the proportion of care and support costs being paid for from public funds;
 - A more joined up service, with social care, the NHS, housing support services and the social security benefits system all better integrated;
 - Easy access to information and advice for everyone, regardless of their circumstances;
 - Personalised care and support, so that the needs and aspirations of each individual person are met;
 - A more universal funding system, ending the situation where many people get no support at all from public funds;
 - More support for carers, recognising their vital role, supporting them and ensuring that they are not obliged to take on too much responsibility for care;
 - Building a sound evidence base on the effectiveness and cost effectiveness of different forms of care and support. (Paragraph 223)
- 17.** The current social care system is complex and opaque. This is substantially down to the fact that it has been the subject of countless piecemeal reforms since its creation in 1948. It is underpinned by an outdated structure of numerous Acts of Parliament, case law, regulations, directions, guidance and circulars, much of which are anachronistic and inconsistent with current policy and modern thinking about equality, human rights, dignity, personalisation and autonomy. (Paragraph 224)
- 18.** We welcome the Law Commission’s commitment to thorough reform of social care law to ensure it becomes consistent, coherent and up-to-date. We recommend that the National Care Service be built on fresh legislative foundations, rather than created through further modifying and patching the existing framework, which is clearly no longer fit for purpose. (Paragraph 225)

Funding

- 19.** The Government’s presentation of the funding options in the Green Paper is significantly flawed. The option of free care wholly funded from general taxation is ruled out by the Government on the grounds that it would place “a heavy burden” on taxpayers of working age. However, many of those who gave evidence to us supported this option and most of the arguments against it can be said to apply just as much to the idea of a free NHS. We recommend the Tax-funded option should be debated in order to gauge whether people are prepared to pay higher taxes for social care or wish to see tax revenue diverted to it from other areas of spending. (Paragraph 266)
- 20.** The DH told us that the Partnership option presented in the Green Paper derived from the model developed by Sir Derek Wanless. However, a key part of Sir Derek’s model which is missing from the DH’s is the idea of the state matching individuals’

contributions pound-for-pound, on top of a basic state contribution, to provide an incentive for people to make provision for themselves. We believe that Sir Derek's original Partnership option should have been included in the debate. (Paragraph 267)

21. We are dissatisfied with the Green Paper's approach to the issue of "hotel costs", which it excludes from the funding options "because we would expect people to pay for their own food and lodging whether or not they were in a care home". It can plausibly be argued that such costs are significantly higher in residential care than they would be in a person's own home. Funding reform that fails to address the risk of incurring uncapped catastrophic costs of this kind risks being quickly discredited and losing public support. The Government must look at options for dealing with this issue, such as an accommodation charge that takes account of people's ability to pay. (Paragraph 268)
22. We are also concerned that the Green Paper pays insufficient attention to how the various funding options might affect people of working age who use social care services. The means-testing element of the "Partnership" and "Insurance" options would risk replicating the existing poverty trap in which many disabled people of working age find themselves. The proposed free system for people of working age alongside the "Comprehensive" option for older people would avoid the poverty trap. However, we are concerned that the transition from one system to the other at the age of 65 could mean that people become worse off merely by reason of growing older. (Paragraph 269)
23. A major deficiency in the Green Paper is that it is silent on the question of the overall "funding envelope" for social care, i.e. how much money, from all sources, will be spent on people with care and support needs in future. This leaves the Green Paper unable to indicate the scope of the new system. The state of public finances as a result of the credit crunch, the bank bailouts and the recession clearly makes the question of future spending levels particularly problematic. However, the issue cannot be ducked. We need to know in hard cash terms what future overall social care funding will be. (Paragraph 270)
24. Ahead of fundamental reform, there is scope to mitigate significantly the worst aspects of the existing funding system quickly and relatively cheaply. This is not to argue for minor change as an alternative to major reform, but rather to make the case for addressing some of the deficiencies as a matter of urgency. We recommend that the following measures be taken immediately:
 - The capital thresholds in the means test must be substantially raised in order to ease the burden on people of relatively modest means.
 - Consideration should be given to some form of "cap" to limit people's liability to pay from their own resources before they qualify for public support.
 - Universal access to the deferred payment mechanism (which allows people to avoid having to sell their home during their lifetime to fund residential care) must be introduced.

- The presumed “tariff income” on capital between the two thresholds is punitive must be substantially reduced.

The Personal Expenses Allowance for people in residential care is far too low and fails to ensure dignity or opportunities for people to maintain their social and family relationships. It must, as a minimum, be doubled. (Paragraph 271)

Free Personal Care at Home Bill

25. We acknowledge that the Government is itself bringing forward significant interim reform of social care through the Free Personal Care at Home Bill. However, we have strong misgivings about this. The proposal for free personal care should be substantially increased, consistent with the introduction of a National Care Service. (Paragraph 293)
26. For the Government suddenly to announce this new policy just weeks after publishing the Green Paper, and in the middle of the consultation period, smacks of policy-making on the hoof. The haste with which the proposals have been assembled is all too apparent in their shortcomings. (Paragraph 294)
27. Since only part of the social care system is to be changed, there is a risk of creating perverse incentives and introducing unanticipated consequences. Witnesses told us that families will have an incentive to try and keep people out of residential care longer than is appropriate, in order to continue receipt of free care. Councils, meanwhile, will have opposite incentives to place people in residential care prematurely, or to manipulate their eligibility criteria so that people being cared for at home are not classified as having higher levels of need. (Paragraph 295)
28. Furthermore, estimates of the likely levels of demand and cost appear low, and there is a risk that the reform could be substantially underfunded. Local authorities have warned that they will not be able to fund their share of the costs from efficiency savings, as the Government intends. This could result in rationing or cuts in other services, including aspects of social care. Meanwhile, the DH has yet to make clear how exactly it will find its share of the funding. It has indicated that some will come from public health and research budgets, which could be detrimental to the long-term interests of NHS patients. (Paragraph 296)
29. As we have stated, the option of a free social care system is one that needs to be debated and considered. However, it is not helpful for the Government to rush in a poorly thought-out and very circumscribed form of free care, as it is doing, rather than it being an integral part of a National Care Service. (Paragraph 297)

“Fully national” or “part local/part national” system

30. Whether the National Care Service should be a national system locally provided (“fully national”) or a local system with national standards (“part local/part national”) is a key area of controversy. The argument in favour of local accountability, along with flexibility to meet local needs and priorities, is very persuasive. On the other hand, the “fully national” option would clearly be the best

way to ensure more clarity and consistency in provision; it would also seem to be an effective means of bringing about full integration of health and social care. The lack of detail in the descriptions of the two options given in the Green Paper makes it difficult to arrive at a definitive view one way or the other. In particular, the Government must make clear whether the fully national option will involve a funding allocation mechanism that takes account of differing local costs. (Paragraph 305)

Personalisation

31. Although there is effectively unanimous agreement in principle with personalising care and support, the pace of change remains slow. However, “transformation” promises to take social care into uncharted waters and the profound ramifications, and risks, of this need to be fully considered and worked through. (Paragraph 352)
32. There has been confusion about whether the Government is pressing ahead with Individual Budgets (combining various funding streams in addition to social care moneys) or instead adopting the less ambitious model of Personal Budgets (involving social care funding only). The policy, and the associated terminology, must be made absolutely clear, as well as the basis for whatever decisions are taken. (Paragraph 353)
33. The Secretary of State told us that personalising social care is part of an aspiration to remodel drastically all public services “over the next 20 years” and the “implications of all of this are pretty vast”. The Government appears to have a goal of bringing together all disability-related expenditure while giving individual disabled people control of all the sums available to them, so they are better able to use them to meet their particular needs. There is a logic to this, but it will raise some contentious and difficult issues. For instance, personal health budgets, which are currently being piloted in the NHS, raise the thorny questions of top-ups and vouchers (on which basis the Government itself ruled out individual budgets for healthcare as recently as 2006). (Paragraph 354)
34. The idea of reforming disability benefits for older people (Attendance Allowance and Disability Living Allowance) by merging the budget for these into social care funding has been particularly controversial. Many of the concerns that have been expressed about the likely consequences of this demand careful attention. It is feared that some people would be left worse off if universal, needs-based and entitlement-led social security benefits are replaced with means-tested, rationed and cash-limited social care provision. The Government has given assurances that there would be “no cash losers” under transitional guarantees for existing benefit recipients. However, no such guarantees would apparently extend to people who develop a care need in future, who could be worse off under a new system than they would have been under the current one. (Paragraph 355)
35. In justifying this proposal, the DH told us about wealthy claimants allegedly using AA payments to fund Saga cruises. We believe this kind of “policy-making by anecdote” is not helpful and risks disparaging people who have genuine care and support needs. Research by Professor Ruth Hancock and her colleagues indicates

that disability benefits are a lifeline to many people, with significant needs and without great wealth, who often don't receive help from the social care system, enabling them to meet costs of daily living. If the DH has hard evidence to the contrary, it should be published. We also note that there appears to be a tension, if not a contradiction, in the Government's policy in that, while it says it is committed to more universalism in care and support, in this case it appears to be intent on going in the opposite direction. (Paragraph 356)

36. Adequate funding is clearly vital to personalisation, which must not be seen as a cost-saving exercise; it may well cost more to provide adequate personalised care and support. Some people in receipt of Direct Payments have found that inadequate funding and inflexible Resource Allocation Systems make it difficult for them to meet their needs without topping up from their own resources. Personalisation must not mean that people who use services are simply turned into rationers of their own care and support, having to make choices which compromise their ability to meet their needs or to maintain their dignity. (Paragraph 357)
37. It must be recognised that not every person who uses social care services will want to take on an entrepreneurial and managerial role as commissioner of their own care and support. Nor should it be assumed that taking on such a role is the only means by which people can be empowered and made full partners in their own care. The potential of "co-production" (i.e. full partnership between providers and people who use services) to allow personalisation of mainstream services, including residential care, should be fully explored within the "transformation" agenda. (Paragraph 358)
38. There are concerns about the right of people who use services such as day care centres to continue doing so, if that is their preference. Such services should not simply be shut down with people being told that it is now down to them to act as commissioners. In some cases it may be appropriate to "ringfence" services for those people who wish to continue using them, although this should not be an excuse to protect outmoded and poor quality services. (Paragraph 359)
39. Where people do act as their own commissioners, information, advice, advocacy and brokerage services must be available and must not be funded from people's own resource allocations. Offloading such responsibilities and costs onto people who use services could seriously curtail or negate the potential benefits of personalisation. (Paragraph 360)
40. People commissioning their own services in some areas may find that the market fails and they are unable to procure the care and support they need, particularly in rural areas. It is not certain that councils will necessarily have the capacity or the capability to act as effective market managers in such situations. (Paragraph 361)
41. Personalisation necessarily entails enabling people who use services to take risks on their own behalf, as part of assuming control of their own care and support. However, there are contentious issues concerning the nature and extent of such "risk transfer". Adult-protection and safeguarding policies (consistent with councils' duty of care) must be tailored to situations where people are directing their own care and support. Many people will be comfortable with managing risks themselves and

should be free to do so, but it is imperative that others are able to access appropriate safeguarding mechanisms. The risk of placing unreasonable demands on carers, either as care providers or as care managers, must also be acknowledged and considered. (Paragraph 362)

42. There are fears about the possible emergence of an unskilled, casualised, unregulated, and potentially exploited, workforce of Personal Assistants (PAs) operating in a semi-informal “grey” market. Local authority “banks” of PAs, which people may choose to commission from if they wish, may be one way of addressing such concerns. There seems to be agreement that people employing PAs should always be given the option of running Criminal Records Bureau checks on prospective employees. Beyond this, however, there are differing views on whether PAs should be subject to mandatory regulation and obliged to register with the Independent Safeguarding Authority under the new Vetting and Barring System. Without a “level playing field” in regulation between PAs and social care staff employed by councils and others, unsuitable staff could migrate from regulated sectors into unregulated PA roles. Nonetheless, many people who employ PAs will insist that they should be free to choose who they wish to work for them. There should be a regulated option for those who wish to use this route, but people who prefer not to use it, and give informed consent to accept the risks that may arise, should be free to do so. Strong safeguards must, though, be put in place to protect the vulnerable. (Paragraph 363)

The social care workforce

43. It is clear that the social care workforce as a whole is increasingly in a state of flux, with existing roles changing and others emerging as new models of care and support provision develop. The role of social workers in particular in a radically changed social care system is still unclear, with contending views being expressed. Plans to extend regulation to the rest of the social care workforce now seem to be in disarray. We are concerned at what appears to be the apparent lack of an overarching strategic vision for the future social care workforce, and we recommend that this be addressed as part of social care reform. (Paragraph 370)

The way forward

44. While there is welcome consensus on several aspects of social care reform, a number of key issues remain highly contentious and insufficiently addressed. Many witnesses agreed that worthwhile and lasting reform will only be achieved if consensus can be reached on these issues too, so that the necessary tough decisions can be taken with broad popular support. (Paragraph 371)
45. Achieving consensus on all these difficult and enduring issues requires calm, rational deliberation and an informed national debate. We would have liked to see all the political parties come together in that spirit to map out a programme of sustainable reform. Instead, regrettably, the Government is hastily drafting a White Paper while also rushing through Parliament a hurriedly concocted Bill that cuts across its own Green Paper, in a febrile atmosphere of unedifying pre-election party-political squabbling and point-scoring. (Paragraph 372)

46. There is still an opportunity, in advance of the demographic challenges to come with the ageing of the “baby boomers”, to reform the social care system, achieving consensus and creating a lasting solution that would represent a “Beveridge” model for our time. Current and future generations will be betrayed if the failure to achieve consensus means that social care reform is once more left to languish near the bottom of Government’s list of priorities in the next Parliament. (Paragraph 373)

Glossary

ADASS	Association of Directors of Adult Social Services
ADLs	Activities of Daily Living
AEF	Aggregate External Finance
CASSRs	Councils with Adult Social Services Responsibilities
CQC	Care Quality Commission (2009 onwards)
CSCI	Commission for Social Care Inspection (2004–09)
ELSA	English Longitudinal Study of Ageing
FACS	Fair Access to Care Services
GHS	General Household Survey (now the General Lifestyle Survey)
IBSEN	Individual Budgets Evaluation Network
IADLs	Instrumental Activities of Daily Living
ILF	Independent Living Fund
JRF	Joseph Rowntree Foundation
LGA	Local Government Association
MS	Multiple Sclerosis
ONS	Office for National Statistics
PA	Personal Assistant
PADLs	Personal care-related Activities of Daily Living
PDS	Parkinson's Disease Society
PEA	Personal Expenses Allowance
PSS	Personal Social Services
PSSRU	Personal Social Services Research Unit
RNF	Relative Needs Formula
RSG	Revenue Support Grant

Annex 1: Conventional modes of social care

Social care services have conventionally (including in official policy) been categorised in terms of Personal Care and Practical help. **Personal care** is help with Personal care-related Activities of Daily Living (PADLs). These relate to self-care (washing, bathing, dressing and undressing, etc.; eating and drinking; continence; mobility; managing prescribed treatment; behaviour management and personal safety), as well as supervision, advice, encouragement, emotional and psychological support, etc. Personal care is sometimes defined as non-healthcare services that involve “touching the body”. **Practical help** is assistance with Instrumental Activities of Daily Living (IADLs), such as cleaning, cooking, shopping and participating in leisure activities.

These services have been seen (again according to conventions that have been reflected in policy) as provided in settings that are either residential or non-residential / community-based.

Residential care settings include the following:

— **Residential homes**

These provide personal care along with, where appropriate, nursing care from visiting District Nurses (employed by local NHS Community Nursing Services).

— **Supported housing / sheltered housing**

In this setting, residents receive personal care and, where appropriate, nursing care, on the same basis as in a residential home, but retain a degree of independence. They live in their own self-contained accommodation with support available round-the-clock, usually from an on-site warden. “Extra-care housing” is a form of sheltered accommodation with additional services, such as the provision of meals and laundry.

— **Nursing homes**

These provide both personal care and intensive nursing care (provided by registered nurses employed by the home; such care is now funded by the NHS for all nursing home residents). The distinction between nursing homes and other types of residential care is becoming less marked as all forms of residential care increasingly cater for people with high levels of dependency.

— **Shared Lives Schemes / Adult Placement Schemes**

These are a type of “adult fostering” service, whereby individuals and families in local communities provide, in their own homes, care and accommodation for one person (or sometimes a small group of people). This form of care is currently only provided for a very small number of people.

Non-residential / community-based settings include the following:

— **Homecare services**

These provide help with PADLs. Care workers can be visiting or live-in.

— **Home help services**

These provide practical help with IADLs.

— **Drop-in / day care centres**

These communal services provide services including hot lunches, entertainment and diversionary activities, adult education, bathing facilities, chiropody / podiatry (footcare), and facilities for self-help and health education groups.

— **Home meal services (meals-on-wheels)**

This service is provided for people who are unable or unlikely to cook for themselves.

— **Professional support**

This includes services such as occupational therapy, which assists people with impairments and disabilities to achieve health and well-being by improving their ability to carry out daily activities.

— **Short-term residential care or overnight respite care**

This entails taking a person into a residential setting for a very short time, assisting carers, by allowing them time off from caring. Respite care can be provided as part of Shared Lives Schemes / Adult Placement Schemes.

— **Provision of specialist equipment and home adaptations**

This includes items such as ramps, hand-rails, hoists and stair lifts. It is often funded through the Disabled Facilities Grant (which is administered by borough / district councils where there is two-tier local government).

— **Grant Funded Services**

These are schemes to help people to live more independently in their own homes. Unlike other social care services, clients are able to approach the provider organisations directly, without assessment, referral or the organising of a package of care.

Annex 2: New approaches to social care

For decades it has been recognised that caring for people with long-term conditions and disabilities in institutions (the successors to workhouses and asylums) is for the most part inappropriate and even inhumane, denying people dignity and autonomy.

It has increasingly been realised that conventional patterns of non-institutional care also, in their own way, place unacceptable limits on people's lives. This has been almost entirely due to ideas developed by disabled people themselves, through **disability politics** and the **disability movement**.

A key idea to emerge from the disability movement was that of the “**social model of disability**”. It was argued that disability was conventionally conceived of in terms of a “medical model”. This defined disabled people by reference to their physical or intellectual impairments and saw them as needing to adapt to the rest of society. The medical model saw disabled people as: dependent upon interventions by medical (and other) professionals to address what were seen as their deficiencies or deviations from the norm; a burden to their families; and objects of pity, condescension and charity. The medical model was seen to have led to such dangerous notions as eugenics and “social hygiene”.

According to the social model of disability, it was viewing disabled people from the perspective of the medical model that actually “disabled” them, not their impairments as such. It was argued that disabled people were as entitled as anyone else to live full, autonomous and independent lives. To deny this was no less than a form of discrimination, a denial of civil and human rights, a form of segregation or Apartheid, as unjust as discrimination on the basis of race, gender or any other arbitrary characteristic. (The term “disablism” has been used, by analogy with racism.) The onus was very clearly on society to accommodate itself to disabled people, not the other way around.

On the basis of this perspective, it is argued that social care services must be “**person-centred**”, starting out from the perspective of the individual person rather than the requirements of the service itself. Each person's particular needs, strengths, preferences and other attributes must be fully taken into account. The care and support for each individual person should start out from their own conception of what they need to become full, equal members of society, not from preconceived notions based on their particular impairment. Each person must be recognised as best placed to make decisions about their own life. The aim of care and support should be not just to meet basic personal needs (those that are typically characterised in terms of personal care and practical help) but to facilitate the fullest possible participation in social, educational, economic and other life experiences and the exercise of self-determination.

A crucial insight arising from this perspective is that social care provision should be designed to help meet individual people's particular needs and bring about desired outcomes for them. Conventionally, however, social care has been arranged and structured according to other considerations. People who use services have been categorised according to their particular condition (age and frailty, a learning disability, etc.), with presumptions made about needs and desired outcomes on that basis. Needs have been arbitrarily divided up (Personal care Activities of Daily Living, Instrumental Activities of

Daily Living, nursing care, etc.), in line with administrative and funding arrangements. Menus of fixed forms and types of service (care in a residential home, homecare, meals-on-wheels, etc.) have been the only options available for meeting needs and delivering outcomes.

This insight informed the concept of “**self-directed**” or “**user-directed**” care and support, which is associated with the “**independent living**” movement. The central principle of self-directed care and support is that the person using the service is given control over when, how and by whom that care and support are provided. The person using the service thus exercises choice and control, rather than being a passive and dependent recipient of services provided or commissioned on their behalf.

For the independent living movement, the indispensable means of bringing this about is **Direct Payments**, i.e. replacing services in kind with cash payments to the person using services, which they can use to meet their needs. Direct Payments are often used to enable people to act as a “micro-employers” of their own **Personal Assistants**.

Recognition that this is not appropriate to all people who use services has led to the development of **Personalised Budgets**. These enable each person to manage for themselves the budget allocated to provide them with care and support (with the option of being helped to do so by others, or handing control of the budget to a third party to manage on their behalf). The budget can be taken partly or wholly in the form of a Direct Payment, but need not be. The term **Personal Budgets** has been used to describe such budgets where they consist only of social care funding and **Individual Budgets** where they also include other streams of funding (although there appears to be some confusion over the use of these terms).

Another idea associated with new approaches to social care that has gained particular currency in recent years, although it is not new, is that of “**co-production**” (sometimes referred to as “co-creation” or “parallel-production”). According to this, people who use services and those who provide them can work together to make services more responsive, effective and suited to people’s needs. Co-production can be seen as distinct from (although not necessarily at odds with) other, more individualised, entrepreneurial, “managerialist” and “consumerist”, approaches to involving people who use services.

The term “**personalisation**” is now often used as a catch-all term for new ways of thinking about and arranging care and support.

The social model of disability has had a significant impact on the language and terminology used in social care. The term “**disabled people**” is preferred to “people with disabilities”, as the former is seen as expressing the idea that it is society that disables people not their impairments as such (however, the terms “learning disabled people” and “people with a learning disability” are both commonly used). The term “service user” is seen as too tied to old models of social care and the alternative “**people who use services**” is now increasingly used. The term “care” is sometimes criticised as having connotations of passivity and dependency; the alternative terms “**support**” or “**care and support**” are now increasingly being used.

Appendix 1: Transformation objectives and milestones

These five key priorities, and milestone dates, for adult social care transformation were agreed in September 2009 by the DH, ADASS and the LGA:

	April 2010	October 2010	April 2011
<p>Effective partnerships with People using services, carers and other local citizens</p>	<p>That a communication has been made to the public including all current people who use services and to all local stakeholders about the transformation agenda and its benefits for them.</p> <p>That the move to personal budgets is well understood and that local people who use services are contributing to the development of local practice. [By December 2009]</p> <p>That users and carers are involved with and regularly consulted about the councils plans for transformation of adult social care.</p>	<p>That local people who use services understand the changes to personal budgets and that many are contributing to the development of local practice.</p>	<p>That every council area has at least one user-led organisation who are directly contributing to the transformation to personal budgets. [By December 2010]</p>
<p>Self-directed support and personal budgets</p>	<p>That every council has introduced personal budgets, which are being used by existing or new people who use services/ carers.*</p>	<p>That all new people who use services / carers (with assessed need for ongoing support) are offered a personal budget.</p> <p>That all people who use services whose care plans are subject to review are offered a personal budget.**</p>	<p>That at least 30% of eligible people who use services/carers have a personal budget.</p>

* The ADASS/LGA survey showed 8% was already the national average in March 09 (although it also suggested that the majority of authorities were below this average). It is believed that Councils should have reached a 10% minimum target by March 2010, if they are going to guarantee the 30% target for 2011; the survey itself indicated that only around 20 authorities were not expecting to have reached a 10% level by March 2010.

** Given the expectation that people who use services receive reviews at least annually, this milestone may in itself drive an allocation of PBs in excess of the 30% target for April 2011.

	April 2010	October 2010	April 2011
Prevention and cost effective services	That every council has a clear strategy, jointly with health, for how it will shift some investment from reactive provision towards preventative and enabling/ rehabilitative interventions for 2010/11. Agreements should be in place with health to share the risks and benefits to the 'whole system'.	That processes are in place to monitor across the whole system the impact of this shift in investment towards preventative and enabling services. This will enable efficiency gains to be captured and factored into joint investment planning, especially with health.	That there is evidence that cashable savings have been released as a result of the preventative strategies and that overall social care has delivered a minimum of 3% cashable savings. There should also be evidence that joint planning has been able to apportion costs and benefits across the 'whole system'.
Information and advice	That every council has a strategy in place to create universal information and advice services.	That the council has put in place arrangements for universal access to information and advice.	That the public are informed about where they can go to get the best information and advice about their care and support needs.
Local commissioning	That councils and PCTs have commissioning strategies that address the future needs of their local population and have been subject to development with all stakeholders especially people who use services and carers; providers and third sector organisations in their areas. These commissioning strategies take account of the priorities identified through their JSNAs.	That providers and third sector organisations are clear on how they can respond to the needs of people using personal budgets. An increase in the range of service choice is evident. That councils have clear plans regarding the required balance of investment to deliver the transformation agenda.	That stakeholders are clear on the impact that purchasing by individuals, both publicly (personal budgets) and privately funded, will have on the procurement of councils and PCTs in such a way that will guarantee the right kind of supply of services to meet local care and support needs.

Formal Minutes

Thursday 4 March 2010

Members present:

Mr Kevin Barron, in the Chair

Charlotte Atkins
Mr Peter Bone
Sandra Gidley
Stephen Hesford

Dr Doug Naysmith
Dr Howard Stoate
Dr Richard Taylor

Draft Report (Social Care), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 373 read and agreed to.

Summary agreed to.

Annexes agreed to.

A Paper was appended to the Report as Appendix 1.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Thursday 11 March 2010 at 9.30 am

Witnesses

Thursday 29 October 2009

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

Thursday 5 November 2009

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

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

Thursday 12 November 2009

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

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

Thursday 19 November 2009

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

Mr Chris Horlick, Managing Director of Care, Partnership Life Assurance Company Ltd, and **Mr William Laing**, Economist, Laing & Buisson

Thursday 26 November 2009

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

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

Thursday 3 December 2009

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

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

Thursday 7 January 2010

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

List of written evidence

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

SC

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

- 40 National Care Association
- 41 City of London Corporation
- 42 Multiple Sclerosis Society
- 43 Citizens Advice Bureau
- 44 Skills for Care
- 45 The NHS Confederation
- 46 Social Care Institute for Excellence
- 47 Professor Pat Thane
- 48 Professor Anthea Tinker
- 49 Professor Caroline Glendinning
- 50 General Social Care Council

List of further written evidence

The following written submissions were received after the publication of *Social Care: Written evidence*, HC 1021, Session 2008–09. They are reproduced with the Oral evidence in Volume II of this Report.

- 1 Parkinson's Disease Society (SC 19A)
- 2 Scope (SC 51)
- 3 Universities of Essex and East Anglia (SC 52)
- 4 Carol and Douglas Batchelor (SC 53)
- 5 COMPAS (ESRC Centre on Migration, Policy and Society, University of Oxford) (SC 54)
- 6 MAP2030 Research Group (SC 55)
- 7 Anchor Trust (SC 56)
- 8 Circle Anglia (SC 57)
- 9 Resolution Foundation (SC 58)
- 10 Dementia Services Development Centre (SC 60)
- 11 Equality and Human Rights Commission (SC 61)
- 12 Department of Health (SC 01B)

List of unprinted evidence

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

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

List of Reports from the Committee during the current Parliament

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2009–10

First Report	Alcohol	HC 151
Second Report	Work of the Committee 2008–09	HC 152

Session 2008–09

First Report	NHS Next Stage Review	HC 53 (Cm 7558)
Second Report	Work of the Committee 2007–08	HC 193
Third Report	Health Inequalities	HC 286 (Cm 7621)
Fourth Report	Top-up fees	HC 194 (Cm 7649)
Fifth Report	The use of management consultants by the NHS and the Department of Health	HC 28 (Cm 7683)
Sixth Report	Patient Safety	HC 151 (Cm 7709)
First Special Report	Patient Safety: Care Quality Commission, Monitor, and Professor Sir Ian Kennedy's Responses to the Committee's Sixth Report of Session 2008–09	HC 1019

Session 2007–08

First Report	National Institute for Health and Clinical Excellence	HC 27 (Cm 7331)
Second Report	Work of the Committee 2007	HC 337
Third Report	Modernising Medical Careers	HC 25 (Cm 7338)
Fourth Report	Appointment of the Chair of the Care Quality Commission	HC 545
Fifth Report	Dental Services	HC 289 (Cm 7470)
Sixth Report	Foundation trusts and Monitor	HC 833 (Cm 7528)
First Special Report	National Institute for Health and Clinical Excellence: NICE Response to the Committee's First Report	HC 550

Session 2006–07

First Report	NHS Deficits	HC 73 (Cm 7028)
Second Report	Work of the Committee 2005–06	HC 297
Third Report	Patient and Public Involvement in the NHS	HC 278 (Cm 7128)
Fourth Report	Workforce Planning	HC 171 (Cm 7085)
Fifth Report	Audiology Services	HC 392 (Cm 7140)
Sixth Report	The Electronic Patient Record	HC 422 (Cm 7264)

Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815 (Cm 6922)
Fourth Report	Independent Sector Treatment Centres	HC 934 (Cm 6930)