THE CENTRE FOR SOCIAL JUSTICE

Transforming care for the poorest older people

A CSJ report ahead of the Government's White Paper on social care

April 2012

1. Introduction

Over the last two years the Centre for Social Justice (CSJ) has undertaken extensive primary research into the state of social care for the poorest older people in Britain. Culminating in the publication of two major reports – *The Forgotten Age* in November 2010 and *Age of Opportunity* in June 2011 – the CSJ took evidence from hundreds of professionals working with the most disadvantaged elderly: social workers, GPs, palliative community care nurses, hospital geriatricians and psychiatrists, adult social care directors, care home and home care workers and charity leads. In addition to this, the CSJ interviewed many older people – hearing them speak for themselves about their first-hand experience of the care system. The picture which emerged was a system at breaking point, all too often failing miserably the people it was set up to help.

Yet while the current means-tested system is at breaking point, the reform proposal currently under consideration is mainly concerned with extending eligibility for care and in effect protecting the housing wealth of those fortunate enough to have accrued it. As it prepares to publish its social care White Paper this spring, the Government risks forgetting the very poorest elderly and focussing its limited resources on the wrong group.

2. Fifteen years of faffing

For over fifteen years there have been headlines announcing the crisis in social care. These have been consistently coupled with both commitments from policy-makers to tackle that crisis and a plethora of proposals about how to do so. Yet due to a lack of governmental leadership, political consensus and social urgency, far reaching reform has been put off. In 1998 the majority opinion of the Royal Commission on Care was roundly rejected by the Government which had set it up. By 2010 a last ditch attempt by the previous Government to take action – a proposed National Care Service – was buried in an acrimonious debate about how to pay for what would be in effect the establishment of a second NHS. Until now, therefore, reform has been kicked into the long grass.

In an act mirroring New Labour's, one of the first steps this Government took was to commission economist Andrew Dilnot to review how social care should be funded in the future. A year later, Andrew Dilnot delivered on his brief, producing a careful, thorough going and far-reaching report. At the heart of *Fairer Care Funding*, Andrew Dilnot, along with fellow commissioners Jo Williams and Norman Warner, recommended introducing a cap on what any one individual should have to pay towards their care. In addition, they have proposed raising the national threshold at which an individual contributes from £23,250 to £100,000.

3. Is doing Dilnot enough?

Since its publication in June 2011 the Dilnot report has received unprecedented backing and media attention. An often divided care 'sector' has rallied around the proposals in a remarkably unified way. Age UK has formed a Care and Support Alliance, bringing together major national charities such as Marie Curie, the Alzheimer's Society, Carers UK – to campaign for the Government to implement Dilnot's recommendations. The Labour party, instinctively supportive of the report, has consistently called for cross-party talks. And across the political spectrum the press has zeroed in on the issue of finding a long-term solution, with almost everyone urging a green light for Dilnot. As many commentators have said, on the table there is finally an idea everybody likes. For all those urging reform for thirteen years, the Government's forthcoming White Paper on Social Care (and accompanying 'Progress Report' on funding) constitutes a once-in-a-generation opportunity to reform a system largely unchanged since its inception in 1948.

Before the CSJ adds its unequivocal support, however, it is critical to step back and reflect on a key point about the political debate on care which has been missed. Calls for reform, whatever their provenance, usually fall into two categories:

- First, those to aid the plight of older people whose social care is not currently being funded by the state because they are financially ineligible. In his first party conference speech as Prime Minister in 1997, Tony Blair said 'I don't want a country where the only way pensioners can get long-term care is by selling their home.' Translated into policy, any attempt to make things fairer for older homeowners involves significant *expansion* of the current formal care system (which was first set up in 1948, unlike the NHS, to be a means-tested system for the poorest);
- A second set of grievances relate to the current system. Take demands for more dignified home care. The frailest older people should no longer have to suffer 'flying visits' (carers rushing in and out of their homes to complete essential tasks), the Equality and Human Rights Committee insisted in a damning report last November. Or take calls for better palliative care in nursing homes so that residents need not be routinely hospitalised at the end of their lives. These are both calls to change the system the poorest receive right now.

Now Andrew Dilnot's core proposals – capping the amount someone pays for care and significantly raising the capital threshold – clearly fall into the first camp. While Dilnot admits that 'the current means-tested system is under extreme strain' his report is preoccupied with answering the question he was set – how to guard against individuals losing everything to pay for their care.[1] The report says little about ameliorating the current system which is in large part failing many. In the media, public and stakeholders' minds, *all hope for reform of social care has been pinned upon the fate of Andrew Dilnot's proposals*. Yet those proposals do not address the means-tested system for those who find themselves dependent on the state in their old age, having not been fortunate enough to own their own houses.

4. A failing system…

Throughout our evidence-gathering a clear picture emerged of the inadequacy of the system we have today.

- *Care at home.* Low pay, poor training and lack of oversight has led in many places to the very poor quality of home care for the most disadvantaged older people. The findings of the EHRC's review of home care mentioned above very much

[1] *Fairer Care Funding: The Report of the Commission on Funding of Care and Support*, July 2011, p70

corroborates our own findings. One man we interviewed in the London Borough of Southwark, suffering from a terminal and degenerative illness, was in receipt of a maximum care package – four visits a day. 'You can't expect the state to do everything,' he told us, but what did disappoint him was the fact that so many of his care workers were 'in and out of the door in ten seconds.' Yet the blame for what is a common story cannot simply be laid at the door of unaccountable domiciliary care workers. Overwhelmed by the volumes of their visits, often it is the commissioning structures which results in their rushing from home to home, with insufficient time allotted to clients.

- *Care homes*. Of the 400,000 older care home residents in this country (comprising residents of both residential and nursing homes), nearly two thirds are state-funded. And during the course of evidence-gathering the CSJ heard repeatedly about individual councils using their purchasing power to drive down the fees they pay providers. One manager spoke of his local council pushing him to accept one resident. When he refused on the grounds that the price they were offered was simply insufficient to provide quality care for that resident, he told by the council representative: '*You'd better accept it. Six or seven of us (councils) are working as a cartel to fix mother*.'

  Corroborating this view from the other side of the table, a senior commissioning manager at a well-regarded social services' department vented his frustration about the fees his council is able to pay. He acknowledged that the poor pay of care home workers in many places directly results from the care home fees the council pays per resident. Setting aside the Dilnot proposal (and the possibility of councils funding a whole new group of older people with housing wealth), the manager told the CSJ: '*Someone needs to come in and give more investment for the poorest*.' On the ground, on the care home floor, inadequate funding results in underpaid staff and inadequate staffing levels, both detrimental to residents' experience of their last years of life.

5. How much is enough?

The adequacy of public expenditure on social care is frequently contested. Age UK is adamant: '*For years society has tolerated a care system that has gone from bad to worse, for lack of money*.'[2] They claim that between 2004 and the present, while net spending on the NHS has risen by £25 billion, net spending on older people's social care has risen by merely £43 million (0.1 per cent of GDP). Health think-tank, the King's Fund, concurs, arguing that '*the trend towards a decline in spending with fewer people receiving services defies demography*'[3] (for example, over the last five years the number of over 85s has risen by a quarter). And Peter Hay, until recently President of the Association for Adult Social Services' Directors (ADASS), has spoken similarly of the '*undeniable funding gap between the demographically-*

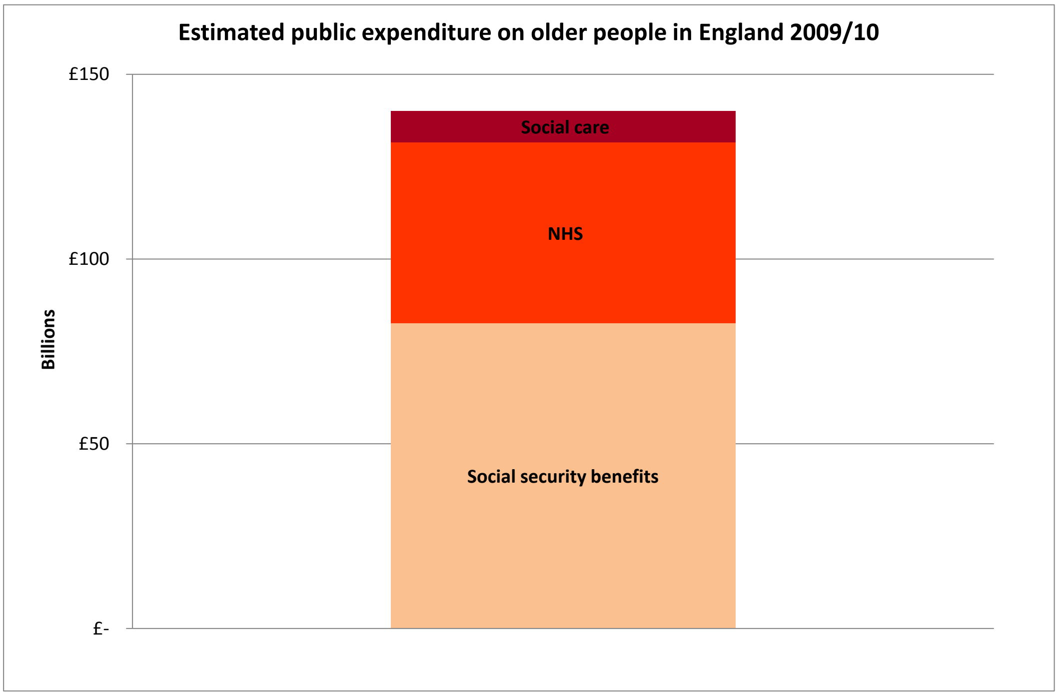
[2] Age UK, *Care in crisis: causes and solutions*, 2011, p3
[3] Richard Humphries, *Social care funding and the NHS: An impending crisis*, The King's Fund, 2011, p4

inspired rise in the costs of social care and the money available within the local authority pot to pay for it.'[4]

Countering this view, the Government points to the additional £2 billion per annum allocated in the 2010 spending review. '*We do not accept the position that there is a gap*', Paul Burstow, Minister of State for Care Services, told the Health Select Committee in January 2012; '*we have closed that gap in the spending review.*'[5]

In response to this debate, two points are particularly salient:

- First, almost £1 billion has been stripped out of social care budgets in England over the course of the last year, according to a recent budget survey by the Association of Directors of Adult Social Services (ADASS). Since the £1 billion made available to councils was not ring-fenced, councils have made savings elsewhere.
- Secondly, what is also clear is that the pattern of public expenditure is undesirable and inadequate. This is something Dilnot himself has made clear. Below is a key chart from his report:



Source: Dilnot report, Fairer Care Funding, p55

Admittedly, this chart includes universal components: 'social security benefits' incorporates the basic state pension; and NHS expenditure covers the cost of providing health care to *all* older people. Nevertheless, at six per cent of the £140 billion spent on older people in England, state expenditure on social care does still appear minimal. A better use of

[4] Peter Hay, 'It's time to come clean over care home fees', www.adass.org.uk/index.php?option=com_content&view=article&id=789:time-to-come-clean&catid=156:press-releases-2012&Itemid=470 (accessed 12-04-12)

[5] Quoted in House of Commons Health Committee, *Social Care: Fourteenth Report of Session 2012-12*, p21

resources, particularly involving more integrated services between health and social care, is clearly called for.

6. What will happen if investment is not made into social care?

Given the profound ways in which the current means-tested social care system is failing, what will happen if *only* the reforms proposed by Andrew Dilnot are implemented by Government? What will be results of the neglect of the current system in favour of its expansion of financial eligibility? In our view:

First, NHS reform will fail…

After a turbulent ride through Parliament, in March 2012 the Government's flagship NHS reform bill was finally passed. Implementation will now commence as GPs, formed in clinical commissioning groups (CCGs) take over commissioning from primary care trusts (PCTs). But the success or failure of the systems-change envisaged by the primary legislation hinges upon what happens to the social care system which exists for the poorest.

Consider hospitals. At 45 per cent, spending on secondary care is by far the largest item of NHS's annual expenditure, and it has also been increasing over the last three years as a proportion of the overall spend.[6] By giving GPs' greater control of commissioning the aim is to get a handle on this spending.

Older people, we know, account for two-thirds of overnight stays in hospitals. During the CSJ's review we heard from hospital consultants, therapists and nurses about the prevalence of 'frequent flyers', older people living in poverty in the community who yo-yo in and out of hospital. Free at the point of use, and always open, accident and emergency departments have in many of the most deprived areas become 'catch-alls' for suffering. Dr Jane Evans, a consultant geriatrician from King's College, Denmark Hill, spoke to the CSJ of the significant numbers of older people turning up at A&E in the middle of winter dressed only in summer clothes. 'Being failed in the community' was how she described their lot. Unless social care improves in many of the most deprived areas, the pressure on the NHS, and upon hospitals in particular, will be unsustainable.

And secondly there will be greater social care need in the future…

One key aspect of the CSJ's primary research into social care has been to understand the crucial role of social workers themselves. The opportunity not only to interview but to shadow social workers has brought into focus their pivotal role in terms of prevention.

Admittedly, social workers working with adults, like the police, have a responsibility for the whole population. (For example, social workers will be called into care homes to respond

[6] National Audit Office, *Department of Health: Health Resource Allocation, Briefing for the House of Commons Health Select Committee*, London: National Audit Office, 2010, p16

to suspicion of neglect or abuse of a *self-paying* resident). But in the main, as one social worker told the CSJ, '*We deal with people in poverty… people who don't have a cent to their name*.' And a large part of this work involves trouble-shooting and time-limited interventions, often at points of crisis, to prevent a particular older person coming to require intense care packages, whether at home or in a long-term care setting. 'See, solve and shut' is the designation given to the category of cases which includes putting plans in place, liasing with family members or the organising of 'reablement' for older people returning to their homes from hospital. ('Reablement' refers to time-limited 'blasts' of care intended to get people back on their feet.)

Many social workers are very aware of how much hinges upon this trouble-shooting, preventative role. '*That's the really good part of the job*,' one tells us; '*put something small in and it makes a big difference. A 90 year-old can be fiercely independent*.' While another contends: '*We should always be doing ourselves out of a job*.'

Again, however, it is difficult to see how the proposals put forward by Andrew Dilnot will help to ease the unprecedented pressure upon teams of social workers operating in the most deprived areas of the country. With the employment of social workers a key line-item in any adult social care budget, the squeeze on the latter is inevitably a squeeze on the former. If nothing is done to relieve that pressure the danger is that prevention goes missing, resulting in the exponential demand for intense care packages from older people for whom smaller interventions might have sufficed.

7. Conclusion

The men and women in receipt of care at the moment are from an extraordinary generation. They lived, grew up and suffered through the war; they rebuilt this country after it. Yet the public system of care now offered to the poorest among them is, to a great extent, broken. And while there is little debate now about the diagnosis – the number of ways in which our system of care fails – it is difficult to see why the cure proposed by the Commission on Funding and Support will do anything to improve the lot of the poorest. Therefore, as it comes to deliver on its promise of a White Paper on social care, the Government must get its priorities right. The greatest priority remains ameliorating a formal care system which at present treats very many very badly: the quality of care provided is of too low a standard and there are many who do not receive care because their needs are not deemed sufficiently severe. The Government must focus much-needed additional funding on this group first before, at a later date, potentially phasing in the Dilnot reforms. It is vital that, in terms of social care reform, the Government runs before it can walk.