



HOUSE OF LORDS

# Library Note

## **Care Bill [HL] (HL Bill 1 of 2013–14)**

This Library Note provides background information ahead of the second reading debate on the Care Bill in the House of Lords on 21 May 2013. The Note summarises the main developments in Government policy since 2010 and sets out the provisions brought forward in the Care Bill. It then highlights two key additions to the Bill since its publication in draft: the Government's response to the funding scheme proposed by the Dilnot Commission and its legislative response to the Francis report. It concludes with reaction to the Bill in the House of Commons during the debate on the Queen's Speech and captures some of the reaction and comment from a selection of organisations and charities.

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## I. Introduction

On 8 May 2013 it was announced in the Queen's Speech that:

Legislation will be introduced to reform the way long term care is paid for, to ensure the elderly do not have to sell their homes to meet their care bills.

(HL *Hansard*, 8 May 2013, [col 2](#))

The Care Bill ([HL Bill 1 of session 2013–14](#)) was introduced to the House of Lords on the following day. The Bill's second reading is scheduled to take place on 21 May 2013.

As introduced, the Bill contains 113 clauses and 8 schedules, amounting to 125 pages. It is divided into four parts. The first part reforms the adult social care system. It proposes consolidation of care and support law into “a single, clear statute, which is built around the person not the service”. The Bill would enshrine the right of carers in England to receive support from their local council and would introduce a duty to meet carers' eligible needs for support. The Bill also proposes a cap on care costs and provides a new legal entitlement to a personal care budget for eligible individuals. Additionally it sets out measures to ensure those in need of care are able to move between local authorities without interruption to their care and clarifies how, were a care provider to go out of business for example, individuals would be protected (Cabinet Office, [Queen's Speech 2013 Briefing](#), 8 May 2013, pp 54–7).

The second part of the Bill relates to care standards, providing the Government's legislative response to the Francis Inquiry into the failings at Mid-Staffordshire hospital. This includes the introduction of “Ofsted-style rating” for hospitals and care homes, empowering the new Chief Inspector of Hospitals at the Care Quality Commission (CQC) to identify problems with care quality and then take action, and making it a criminal offence for care providers to give false and misleading information about their performance.

The third part of the Bill would establish Health Education England (HEE) and Health Research Authority (HRA) as statutory non-departmental bodies (NDPBs). These would “strengthen education and training for health care professionals” and “protect and promote the interests of people in health and social care research” (*ibid*).

The final part of the Bill contains technical matters including consequential amendments and territorial extent. The Bill would apply to England only “save for cross-border provisions in relation to care and support and the Health Research Authority's co-operation duties will apply across the UK” (*ibid*).

In a statement Jeremy Hunt, the Health Secretary, explained the main benefits of the proposals. In terms of the reforms to the social care system, he said:

... older people will not have to fear losing their homes in their lifetime to pay care home fees and everyone with a care plan will be able to have a personal budget to choose how they are cared for.

Importantly, if someone has help to pay for care in the south but wants to move to the north to be closer to their family, they will be able to do so without fear of losing the funding.

Mr Hunt said that the “measures to address the findings of Robert Francis' report” would “improve care and mean that patients will be treated with more compassion and respect”. He added that he

“strongly” believed “that the Chief Inspectors, improved training for staff and making quality as important as finance will improve NHS care” (Gov.uk press release, ‘[Government Publishes Care Bill](#)’, 10 May 2013).

## 2. Background to the Bill

### 2.1 What is Adult Social Care?

#### From the Law Commission report [Adult Social Care](#) (10 May 2011, HC 941)

Adult social care means the care and support provided by local social services authorities pursuant to their responsibilities towards adults who need extra support. This includes older people, people with learning disabilities, physically disabled people, people with mental health problems, drug and alcohol misusers and carers. Adult social care services include the provision by local authorities and others of traditional services such as care homes, day centres, equipment and adaptations, meals and home care. It can also extend to a range of so-called non-traditional services—such as gym membership, art therapy, life coaching, personal assistants, emotional support, and classes or courses. Adult social care also includes services that are provided to carers—such as help with travel expenses, respite care, and career advice. Finally, adult social care also includes the mechanisms for delivering services, such as assessment, personal budgets and direct payments (p 2, para 1.5).

### 2.2 Statistics

The [Health and Social Care Information Centre](#) statistical releases contain a range of information about adult social care.

Below are the most recent statistics in relation to the adult social care activity and expenditure of Councils with Adult Social Services Responsibilities (CASSRs) in England.

#### Activity

*Community Care Statistics, Social Services Activity—England, 2011–12, Final Release* (15 February 2013) contains statistics on the social care activity of CASSRs. It does not cover people who pay entirely for their own care. Academics have estimated that around 170,000 (45 percent) of the registered care home places in England are occupied by self-funders and 170,000 older people pay for care in their own home. It has been suggested that this figure increases to 270,000 if it is widened to include help with activities such as housework and shopping (ibid, p 5). The headline findings of this survey were that:

- The number of contacts from new clients in 2011–12 was 2.1 million (down 3 percent from 2010–11 and up 2 percent from 2006–07). Of these, 1.0 million required a further assessment or commissioning of ongoing service (down 4 percent from 2010–11) while 1.1 million were dealt with at the point of contact (down 3 percent from 2010–11).
- The number of assessments in 2011–12 was 607,000—down 8 percent from 2010–11 and down 7 percent from 2006–07. Of these, 32 percent were assessed within the first two days of making contact with the CASSR and 68 percent went on to receive services as a result of their assessment.

- The number of service users with completed reviews in 2011–12 was 1.0 million—down 13 percent from 2010–11 and down 20 percent from 2006–07.
- The number of people receiving services in 2011–12 was 1.5 million (down 7 percent from 2010–11 and down 18 percent from 2006–07). Of these, 1.2 million received community based services (down 8 percent from 2010–11), 213,000 received residential care (which is less than a 1 percent change from 2010–11) and 86,000 received nursing care (down 1 percent from 2010–11). Feedback from councils suggests that the fall this year is due to a number of reasons which include providing services outside of a formal assessment process and data cleaning. This will also help to explain the reduction in the number of reviews.
- The number of people receiving self-directed support was 527,000 (an increase from 377,000 in 2010–11). Of these, 139,000 received a direct payment—up 11 percent from 2010–11 (section 4). The number of carers receiving self directed support was 78,000 (up 12 percent from 2010–11).
- Of those receiving community based services not in the form of direct payments in 2011–12, 517,000 received home care, 431,000 received equipment, 268,000 received professional support, 159,000 received day care, 70,000 received short term residential care (excluding respite care), 60,000 received meals and 107,000 received other services.
- The number of carers receiving services was 363,000 (down 4 percent from 2010–11 but up 15 from 2006–07). Of these, 48 percent of carers received a carer specific service and 52 percent received information only. This compares to an equal 50 percent split in 2010–11.

(ibid, [p 5](#))

## Expenditure

Information about the money spent on adult social care by CASSRs in England can be found in the statistical release *Personal Social Services: Expenditure and Unit Costs—England, 2011–12: Final Release* (31 January 2013). The main findings were:

- Gross current expenditure by CASSRs on adult social care in 2011–12 was £17.2 billion, compared to £17.0 billion in 2010–11. This is a one per cent rise in cash terms but a decrease of 1 percent in real terms. Over the five years between 2006–07 and 2011–12 real terms expenditure increased by 3 percent. Over the ten year period between 2001–02 and 2011–12 there was an increase in real terms expenditure of 33 percent.
- Over half (52 percent) of expenditure was on older people (those aged 65 and over) in 2011–12. People aged 18–64 with a learning disability accounted for 30 percent of expenditure, while those aged 18–64 with a physical disability accounted for nine per cent, and those aged 18–64 with mental health needs for 7 percent. Other adult services accounted for 2 percent of expenditure and less than 1 percent was spent on asylum seekers and service strategy.
- The proportion of expenditure accounted for by residential care has decreased over the five year period 2006–07 to 2011–12, from 46 percent to 44 percent. Over the

same period the proportion of expenditure accounted for by day and domiciliary care has increased from 41 percent to 45 percent. The remaining 11 percent of expenditure in 2011–12 was spent on assessment and care management.

- Expenditure on Direct Payments for adults was £1.1 billion in 2011–12 compared to £360 million in 2006–07. This is an increase of around 210 percent in cash terms and around 175 percent in real terms. The percentage of expenditure accounted for by Direct Payments to adults has increased, equating to six per cent of gross current expenditure in 2011–12 compared to 2 percent in 2006–07.

(ibid, [p 4](#))

### 2.3 Developments since 2010

In the [Coalition Agreement: Our Programme for Government](#), published following the 2010 general election, the Government set out its plans for the adult social care sector. The document explained the values behind these plans:

The Government believes that people needing care deserve to be treated with dignity and respect. We understand the urgency of reforming the system of social care to provide much more control to individuals and their carers, and to ease the cost burden that they and their families face.

(ibid, p 30)

Specifically, the Government pledged:

- We will establish a commission on long-term care, to report within a year. The commission will consider a range of ideas, including both a voluntary insurance scheme to protect the assets of those who go into residential care, and a partnership scheme as proposed by Derek Wanless.
- We will break down barriers between health and social care funding to incentivise preventative action.
- We will extend the greater roll-out of personal budgets to give people and their carers more control and purchasing power.
- We will use direct payments to carers and better community-based provision to improve access to respite care.

(ibid)

### 2.4 Law Commission (2011)

In 2008 the Law Commission initiated a three-year review into adult social care law. The report, *Adult Social Care*, was published in May 2011. The Commission found that the legal framework for the provision of adult social care services dated back to 1948 and consisted of a “complex and confusing patchwork of legislation”. This legal framework, the Commission noted, made “interpretation and application of the law complex and time consuming” (Law Commission, [Adult Social Care: Summary of Report](#), May 2011, p 1).



The Commission recommended a “consolidation and simplification” which “would be best achieved by establishing a unified adult social care statute” through separate statutes in England and Wales. These new statutes would, it recommended, be part of a three level structure:

1. The statute would set out the core duties and powers of local social services authorities, which would not be subject to further directions or approvals.
2. The second level of our scheme would be regulations made by the Secretary of State or Welsh Ministers, to provide more detail where necessary and to allow for developments of policy in the future.
3. Each Government would also be required to issue consolidated guidance on the new statute in the form of a code of practice. This would be the third level of our scheme, and would provide guidance to local authorities about the implementation and operation of the new statute.

(Law Commission, [Adult Social Care: Summary of Report](#), May 2011)

The Commission stated that the statute should provide a “single, unifying purpose” around which adult social care would be organised. The “overarching purpose” of adult social care, it argued, was “to promote or contribute to the well-being of the individual. In effect, individual well-being must be the basis for all decisions made and actions carried out under the statute” (ibid, pp 1–2). The other key recommendations of the report were:

- putting the individual’s wellbeing at the heart of decision-making, using new statutory principles
- giving carers new legal rights to services
- placing duties on councils and the NHS to work together
- building a single, streamlined assessment and eligibility framework
- protecting service users from abuse and neglect with a new legal framework, and
- for the first time, giving adult safeguarding boards a statutory footing.

(Law Commission, [Adult Social Care: Recommendations](#), 11 May 2011)

## 2.5 Care and Support Commission (2011)

The Care and Support Commission, appointed by the Government in 2010, reported its findings on the current state of the funding of social care in July 2011. On publication of the report, Andrew Dilnot, who chaired the Commission, stated that funding of adult social care had been “ignored for too long”. He said:

The current system is confusing, unfair and unsustainable. People can’t protect themselves against the risk of very high care costs and risk losing all their assets, including their house.

This problem will only get worse if left as it is, with the most vulnerable in our society being the ones to suffer.

(Dilnot Commission website, '[Our Report: Fairer Funding for All—The Commission's Recommendations to Government](#)', July 2011)

The Commission set out a number of recommendations, including:

- Individuals' lifetime contributions towards their social care costs—which are currently potentially unlimited—should be capped. After the cap is reached, individuals would be eligible for full state support. This cap should be between £25,000 and £50,000. We consider that £35,000 is the most appropriate and fair figure
- The means-tested threshold, above which people are liable for their full care costs, should be increased from £23,250 to £100,000
- National eligibility criteria and portable assessments should be introduced to ensure greater consistency
- All those who enter adulthood with a care and support need should be eligible for free state support immediately rather than being subjected to a means test.

(ibid)

The Commission estimated that its proposals—based on a cap of £35,000—would cost the state around £1.7 billion. Mr Dilnot said that the benefits of its proposed system would be that “everybody who gets free support from the state now will continue to do so and everybody else would be better off”. He added “putting a limit on the maximum lifetime costs people may face will allow them to plan ahead for how they wish to meet these costs. By protecting a larger amount of people's assets they need no longer fear losing everything” (ibid).

## 2.6 Government White Paper and Draft Bill (2012)

In July 2012 the Government published a White Paper, [Caring for our Future: Reforming Care and Support](#) (Cm 8378), together with a [Draft Care and Support Bill](#) (Cm 8386), and a paper updating its thinking on funding, [Caring for our Future: Progress Report on Funding Reform](#) (Cm 8381). The White Paper proposed a “new vision” for the care and support system in which:

First, the focus of care and support will be transformed to promote people's wellbeing and independence instead of waiting for people to reach a crisis point. Active communities will reach out to those around them, families and individuals will have better information to plan and prepare for their future, and people will have more options to keep them well and independent.

Second, we will transform people's experience of care and support, with high quality services that respond to what people want. This means that people will have control over their own budget and their own care and support plan. They will be empowered to choose the care and

support that best enables them to meet their goals and aspirations. We will put people, and not institutions, in control.

(HM Government, [Caring for our Future: Reforming Care and Support](#), July 2012, p 8)

The Draft Care and Support Bill was published the same day for public consultation. It was announced that pre-legislative scrutiny in Parliament would also take place on the Bill during the 2012–13 session. The Draft Bill took forward many of the recommendations of the three-year Law Commission review that had concluded the previous year. The Bill proposed:

- new statutory principles which embed the promotion of individual wellbeing as the driving force underpinning the provision of care and support;
- population-level duties on local authorities to provide information and advice, prevention services, and shape the market for care and support services. These will be supported by duties to promote co-operation and integration to improve the way organisations work together;
- clear legal entitlements to care and support, including giving carers a right to support for the first time to put them on the same footing as the people for whom they care;
- set out in law that everyone, including carers, should have a personal budget as part of their care and support plan, and give people the right to ask for this to be made as a direct payment;
- new duties to ensure that no-one’s care and support is interrupted when they move home from one local authority area to another; and a new statutory framework for adult safeguarding, setting out the responsibilities of local authorities and their partners, and creating Safeguarding Adults Boards in every area.

The Draft Bill also included a “small number of critical health measures” that the Government had undertaken to publish in response to debates in parliament on the Health and Social Care Bill. The clauses would:

- establish Health Education England (HEE) as a non-departmental public body (NDPB) to provide the necessary independence and stability to empower local healthcare providers and professionals to take responsibility for planning and commissioning education and training;
- establish the Health Research Authority (HRA) as an NDPB to strengthen its ability to protect and promote the interests of patients and the public in health and social care research, as well as providing assurance that the HRA will continue streamlining the research approvals process and encouraging investment in research; and
- allow for the abolition of the Human Fertilisation and Embryology Authority (HFEA) and Human Tissue Authority (HTA) by amending the Public Bodies Act 2011; this is subject to a public consultation.

(HM Government, [Draft Care and Support Bill](#), July 2012, Cm 8386, pp 5-6)

In the foreword to the Draft Bill, Andrew Lansley, the then Health Secretary, and Paul Burstow, the then Minister for Care Services, said that the Bill represented “an historic reform of care and support

legislation”. They added that “for over 60 years, social care law has been anchored in the post-war period, looking back to the Poor Law for its principles. Whilst other areas have moved forward with modern times and expectations of public services, care and support law has been left unreformed; a web of complicated, overlapping requirements which have led to confusion, challenge and frustration”. The Government’s proposals argued:

... consolidates provisions from over a dozen different Acts into a single, modern framework for care and support. It is intended to do more than bring those Acts together; it achieves a fundamental reform of the way the law works. It places the wellbeing, needs and goals of people at the centre of the legislation to create care and support which fits around the individual and works for them. It provides a new focus on preventing and reducing needs, and putting people in control of their care and support. For the first time, it brings carers into the heart of the law, on a par with those for whom they care.

(ibid, p 4)

The Draft Bill contained no clauses regarding funding. The Government progress report stated “that the principles of the [Dilnot] Commission’s model—financial protection through capped costs and an extended means test—would be the right basis for any new funding model. Protecting people against very high costs would provide peace of mind and enable them to plan and prepare for their future care needs”. The Government required, however, more time to consider the challenges surrounding the issue:

Whilst we support the principles of the approach recommended by the Commission on Funding of Care and Support, and it is our intention to base a new funding model on them if a way to pay for this can be found, there are important questions that need to be addressed about how those principles could be applied to any reformed system. Recognising the current economic situation, we are unable to commit to introducing the new system at this stage. We are keen to work with stakeholders and the Official Opposition to consider the various options for what shape a reformed system could take, based on the principles of the Commission’s model. For example, questions have been raised about the level of a cap. Some people suggested that a higher cap would reduce the cost to the Government, but still provide financial protection and create a greater space for financial services.

(HM Government, [Caring for our Future: Progress Report on Funding Reform](#), July 2012, Cm 8381, p 37)

## **2.7 Social Care Funding: Statement (February 2013)**

On 11 February 2013 Jeremy Hunt, the Health Secretary, announced to the House of Commons the Government’s plans for reforming social care funding. Mr Hunt told MPs that the Government had decided to accept the main recommendations of the Dilnot Commission and was now able to confirm its proposals for funding. He said:

A core principle set out by the Dilnot Commission was that people should contribute to the costs of their own care, but those costs should be limited and protected against the potentially catastrophic costs of care. That should come through a cap on those costs and an extended means test. One person in 10 will be faced with care costs in excess of £100,000, with a small number facing costs significantly higher still. To give everyone peace of mind, from April 2017, we will introduce a cap on the amount that someone over state pension age will be liable to pay.

The Dilnot Commission's original suggestion was for a cap of £25,000 to £50,000 in 2010–11 prices—the equivalent of £30,000 to £61,000 in April 2017 prices. Despite the extremely challenging economic situation in which we find ourselves, we have come as close to that range as possible. The cap will be set at £61,000 in 2010–11 prices or £75,000 once it is introduced in April 2017.

The intention is not that people should have to pay up to £75,000 for their care costs, but that by creating the certainty that this is the maximum they will have to pay, they can then make provision through insurance or pension products so that they are covered up to the value of the cap, thereby reducing the risk of selling their home or losing an inheritance that they have worked hard to pass on to their family. Young people who already have care needs when they turn 18 will now receive free adult care and support when they reach 18. People who develop a care need after 18 but before state pension age will be protected by a cap that is below the £75,000 threshold.

The other measure we propose is to increase significantly the amount of assets a person can hold and still receive financial support for their residential care home costs. Currently, this is set at £23,250. If a person has assets valued above this level, including in some circumstances the value of their home, they receive no support. The Dilnot Commission recommended this threshold be raised dramatically to £100,000 in 2010–11 prices. We accept this recommendation.

From April 2017, the threshold will be increased so that those with assets worth £123,000 or less, equivalent to Dilnot's recommended level, will all receive some degree of financial support for their care costs. People with the fewest assets will receive the most support. This will, for the first time, provide financial protection for those with modest wealth, while ensuring that the poorest continue to have all or the majority of their costs paid.

(*HC Hansard*, 11 February 2013, [cols 592–3](#))

The proposals, Mr Hunt added, meant “everyone will benefit from the peace of mind that a cap will bring. The introduction of a cap and the extended means-tested support will help many people in the most challenging circumstances” (*ibid*).

On costs, he explained that George Osborne, the Chancellor of the Exchequer, had asked his Department to “identify how we pay for the additional costs of these proposals”. He said that the reforms would “cost the Exchequer £1 billion a year by the end of the next Parliament”. This would be “met in part by freezing the inheritance tax threshold at £325,000 for a further three years from 2015–16” and it was agreed that “the remaining costs over the course of the next Parliament will be met from public and private sector employer national insurance contributions revenue associated with the end of contracting out as part of the introduction of the single-tier pension” (*ibid*, [col 593](#)).

Andy Burnham, the Shadow Health Secretary, responded for the Opposition. He told Mr Hunt that the statement was “a modest plan that will make the system fairer than it is today, and we congratulate him on that”. He said that the cap of £75,000 and the raising of the means-test threshold were welcome but although the plan was “a step forward” it was “a faltering one”. The House, he contended, had “been presented with a flawed prospectus today. Vulnerable people will still face rising care charges and homes will still be lost, notwithstanding valiant attempts to put the best possible spin on things in the weekend media” (*ibid*, [cols 594–5](#)).

He told MPs his party saw four problems with the plans:

First, it fails the fairness test. We will only have a durable solution if it can answer this question: will it help every person and every couple to protect what they have worked for, whatever their wealth and savings? I am afraid that the answer is no...

Secondly, the plan is at best a partial solution. With this decision, the Government have prioritised the funding of a cap on care costs with new money, over and above addressing the crisis in council care budgets. Will the Secretary of State confirm that this was against the advice of Andrew Dilnot to the cross-party talks? In practice, it will mean that vulnerable people will continue to face rising charges, as councils put up fees to cope with the growing shortfall in their budgets, making it more likely that those people will, in time, have to pay right up to the new £75,000 cap. To many people, that will not feel like progress...

The third problem is that this package disguises yet another coalition U-turn, this time on inheritance tax... It is ironic, I must say. In 2007, a flagship pledge was made to increase the inheritance tax threshold to £1 million. Just eight weeks ago, the Chancellor said that he would increase the threshold in two years' time. What has happened in the past two months to make him change his mind? Is not this the quickest coalition U-turn yet? The irony will not be lost on people that the Government are now increasing death taxes to pay for their plan. The Secretary of State has also said the rest will be made up from national insurance. Does he think it is fair to ask the working age population to pay for something else, rather than older people?

Finally, the proposal fails to meet the scale of the challenge of the ageing society. It will not lead to more integration of care. Instead, it will entrench the separation between two separate systems: a free-at-the-point-of-use NHS and charged-for social care. Would it not have made more sense, rather than developing these piecemeal plans in isolation, to have set them out as part of a single vision for a sustainable health and care system in the 21st century? The Secretary of State has made progress, but he has missed an opportunity to produce a long-term plan that is fair to everyone and built on cross-party consensus. He has settled for a timid solution when what older people needed was a far bigger and bolder response.

(ibid, [cols 595–6](#))

## 2.8 Joint Committee on the Draft Care and Support Bill (March 2013)

In November 2012 a [Joint Committee of MPs and Peers](#) was appointed to examine the Draft Bill. The Committee was chaired by Paul Burstow, who had left the Government as the Care Services Minister in September 2012. The Committee was required to report by March 2013.

In its report the Committee described the Draft Bill's proposals as "a major reform of the legal framework governing the provision of adult care and support in England" (Joint Committee on the Draft Care and Support Bill, [Draft Care and Support Bill](#), 19 March 2013, HL Paper 143, p 3). It noted that the Bill went "further than just a consolidation by establishing in law, for the first time, that well-being is the guiding principle of decision-making in care and support". Additionally the Bill "significantly extends the rights of adult carers, and it places greater emphasis on prevention". The Committee also noted that, the previous month, the Government had announced it had accepted the main recommendations of the Dilnot report and that clauses reflecting this would be added to the Bill. These amendments, however, had "come too late for us to be able to consider them" (ibid).

In its assessment the Committee acknowledged that “the Draft Bill has been widely welcomed” but asserted that did not mean that “it cannot be improved. There are gaps, risks of unintended consequences and further opportunities to realise the Government’s White Paper vision”. The summary of the report explained that:

Key among these is the need for the Government to work with interested parties to launch a campaign that raises awareness of what the national care and support offer is, how people can plan and prepare for their care needs, and what their rights to care and support are. The scope and limitations of care and support are very poorly understood, and it is clear that without such a national campaign the benefits of reform and of any capped cost system will be significantly diminished. We are concerned that the Government have not yet fully assessed the scale of the change the Bill will bring about.

The eligibility criteria will determine who obtains state funded care and support. Currently, every local authority operates its own interpretation of Government guidance on assessing what constitute eligible needs. To implement Dilnot, the Government intend for the first time to set a national minimum eligibility threshold. We heard evidence that for disabled working-age adults the restrictions placed on eligibility can make a huge difference to their quality of life and their independence. We recommend that, just as local authorities are bound by the Bill’s well-being principle when they make decisions, the Secretary of State should be bound to take this guiding principle into account when designing and setting a national eligibility threshold.

Care and support are not free; there has always been means testing and charging. It is therefore not surprising that the boundary marking the divide between free NHS services and means-tested care and support is contested. The Draft Bill offers new language to describe this boundary. We believe the altered wording shifts the boundary, and may result in more people in residential care falling into the means tested system. This is a serious drafting issue that must be put right.

The introduction of a capped cost system will lead to a large influx of people with needs into the local authority assessment system. This will provide an opportunity for offering information, advice and assistance that can prevent and postpone the onset of greater care needs. The advice made available to those navigating their way through the system should include advice on housing options and on personal finances.

Evidence heard by the Committee has highlighted the crucial role that housing can play in relation to an individual’s well-being, leading to effective and successful hospital discharge arrangements, and safeguarding from abuse and neglect. We make recommendations to improve both the impact and the reach of the reform by recognising housing as a key partner of adult care and support.

A consistent message from our witnesses was that the key to successful integration is the relationships between different organisations, and their cultures. However, the rules should be made less onerous to make it easier for local authorities and the NHS to pool budgets and to commission together. We also believe that the Draft Bill should be amended to allow the Secretary of State to mandate joint budgets and joint commissioning in certain circumstances. The Draft Bill marks a welcome extension of the rights of adult carers. However, the consequence is that young carers are left with their rights defined in “rump legislation” that sets a higher threshold for recognition and support. This is a serious omission which the Government must address.



While the Draft Bill gives local authorities a new role in “market shaping” it does not directly address how services are commissioned. The Government in their White Paper criticise contracting care by the minute as an unacceptable commissioning practice. They should issue guidance to local authorities that explicitly rules out such practices.

The Draft Bill for the first time places the safeguarding of adults on a statutory basis; however we believe there is a need to go further. The responsibilities of local authorities to prevent the abuse and neglect of those at risk must be made explicit, while steps must be taken to ensure that any provider of care and support services—whether from the private or voluntary sector—is subject to the same legal obligations as the local authority itself, including the Human Rights Act 1998. We also recommend that where abuses have taken place there must be corporate criminal responsibility, with organisations and key individuals held to account.

The Draft Bill is predominantly about adult care and support, but also contains important provisions relating to the education and training of NHS workers, and health research. Mostly these have been welcomed by those giving evidence to our inquiry. We make a number of recommendations to improve the functions and objectives of Health Education England and of the Health Research Authority. In particular, we consider that the duties of HEE should be strengthened to facilitate integration of health and social care by ensuring more common training of care staff who switch between the two sectors. We also recommend making the promotion of research a key objective of the HRA, and we propose giving it the responsibility of protecting public safety by ensuring full disclosure of research data.

Finally, in much of the written and oral evidence we have received during the course of our inquiry we heard a consistent message about the inadequacy of funding for adult care and support. As a result care and support have increasingly been rationed and restricted to those with the highest levels of need. This is ultimately self-defeating—shunting costs and reinforcing the dominance of crisis and acute care over approaches that prevent and postpone the need for formal care and support.

(Joint Committee on the Draft Care and Support Bill, [Draft Care and Support Bill](#), 19 March 2013, HL Paper 143, pp 3–4)

### 3. Care Bill (May 2013)

[The Care Bill Explained—Including a Response to Consultation and Pre-legislative Scrutiny on the Draft Care and Support Bill](#) (Cm 8627) explains how the consultation exercise and the Joint Committee’s scrutiny informed the final Bill as introduced. It also sets out in the annex the Government’s response to each of the Joint Committee’s recommendations.

Two key additions have been made to the Bill since it was published in draft. These relate, firstly, to the changes announced in February 2013 to introduce a cap on the costs that people will have to pay for care in their lifetime. The second major addition is Part Two, which relates to care standards. The Government has explained this “delivers a number of elements in the Government’s response to the findings of the Francis Inquiry, which identified failures across the health and care system that must never happen again”. Its response, the Government have said, “will help ensure that patients are the first and foremost consideration of the system and everyone who works in it’ and restore the NHS to its core values” ([p 8](#)).

One clause that was removed from the Bill was the provision to enable the abolition of the Human Fertilisation and Embryology Authority and the Human Tissue Authority. This was announced on



25 January 2013, following a consultation exercise and the Joint Committee’s recommendation to delete the clause (HC Hansard, 25 January 2013, [cols 26–7W](#)).

### 3.1 Overview of the Bill’s Clauses by Purpose

<b>Part One: Care and Support</b>	
<b>General responsibilities of local authorities</b>	<p><a href="#">Clauses 1 to 7</a> set out the general responsibilities of local authorities. They describe local authorities’ broader care and support role towards the local community, including services provided more generally, for instance those with the aim of reducing needs.</p> <p><a href="#">Clauses 8 to 40</a> (and <a href="#">clauses 64 to 66</a>) provide for a person’s journey through the care and support system. These provisions map out the process of assessments, charging, establishing entitlements, care planning, and the provision of care and support. They include provision to create a cap on the costs of care and for local authorities to enter into deferred payment agreements.</p>
<b>Safeguarding adults at risk of abuse or neglect</b>	<p><a href="#">Clauses 41 to 46</a> outline the responsibilities of local authorities and other partners in relation to the safeguarding of adults, including a new requirement to establish Safeguarding Adults Boards in every area.</p>
<b>Provider failure and market oversight</b>	<p><a href="#">Clauses 47 to 54</a> provide for the oversight of registered care and support providers by the Care Quality Commission (CQC), and set out local authorities’ responsibilities for ensuring continuity of care where a provider sustains business failure and ceases to provide a service.</p>
<b>Transition for children to adult care and support, etc.</b>	<p><a href="#">Clauses 55 to 63</a> will support the transition for young people between children’s and adult care by giving local authorities powers to assess children, young carers and parent carers.</p>
<b>Miscellaneous</b>	<p><a href="#">Clauses 67 to 72</a> set out miscellaneous further provisions, including restating the law relating to delayed discharges.</p>

<b>Part Two: Care Standards</b>	
<b>Quality of services</b>	<a href="#">Clauses 74 to 77</a> provide for an extended failure regime for NHS healthcare providers which encompasses quality as well as finance by: enabling the CQC to issue warning notices to NHS trusts and NHS foundation trusts where the services provided by them require significant improvement; extending Monitor's powers to be able to impose additional licence conditions on foundation trusts; and enabling Monitor to make an order authorising the appointment of a trust special administrator for foundation trusts on quality grounds.
<b>Care Quality Commission</b>	<a href="#">Clause 78</a> prevents registered providers from applying for a change to their conditions of registration where the CQC has commenced proceedings to make the same change and <a href="#">clause 79</a> amends provisions relating to the membership of the CQC.
<b>Performance ratings</b>	<a href="#">Clause 80</a> requires the CQC to conduct periodic reviews, assess performance and publish assessment reports in respect of regulated activities and registered service providers. This is to allow for meaningful comparison of services.
<b>False or misleading information</b>	Finally, <a href="#">clauses 81 and 82</a> provide for a new offence for care providers who supply, publish or otherwise make available information that is false or misleading, with associated criminal sanctions.
<b>Part Three: Health</b>	
<b>Health Education England</b>	<a href="#">Chapter 1</a> establishes Health Education England (HEE) as a non-departmental public body.
<b>Health Research Authority</b>	<a href="#">Chapter 2</a> establishes the Health Research Authority (HRA) as a non-departmental public body.
<b>Miscellaneous and general</b>	<a href="#">Chapter 3</a> deals with transfer orders and interpretation provisions in relation to HEE and HRA.

([Explanatory Notes to the Care Bill \[HL\]](#), 9 May 2013, paras 9–24)

## 3.2 New Clauses

### Funding

Clauses 15 and 16 of the Bill contain the Government's proposals for a cap on care cost contributions, as set out by Jeremy Hunt to MPs in February 2013. The Government has since explained that these clauses:

... provide for two key aspects of the new funding system for care and support. This new system, based on the cap on care costs and extended means-test, will define a clear and fair partnership between individuals and the Government, with shared responsibility for care costs. People will still have responsibility for their initial care costs, but in the eventuality that they need a lot of care, they will not face catastrophic costs.

Clause 15 provides regulation-making powers to set the level of the cap and prevents local authorities from being able to charge for the costs of meeting eligible needs once people have reached the cap. The power to make regulations specifying the level of the cap will enable the Secretary of State to amend the cap, and to set different levels of the cap for different age groups. This will enable Government to ensure that people who have eligible care needs when they reach 18 years of age will receive free care and support.

People will remain responsible for a contribution towards general living costs. In their own home, people remain responsible for non-care expenses such as utilities and rent. In residential care, they will pay a contribution of around £10,000 in 2010/11 prices (equivalent to around £12,000 in 2016/17) to help meet expenses associated with room and board. Clause 15 ensures that progress towards the cap will not include people's contribution towards their general living costs.

The cap will be adjusted in line with inflation, and the adjustment will occur once a year. Clause 16 outlines the basis on which this will happen. The clause also requires the record of accrued costs in the person's care account (see clause 30) to be adjusted by the same inflation measure so that everyone's rate of progress towards the cap remains the same. This means that if someone is 50 percent of the way to the cap before the annual adjustment, they will remain 50 percent of the way to the cap after the adjustment. This ensures that the real value of the cap remains constant.

(HM Government, *The Care Bill Explained—Including a Response to Consultation and Pre-legislative Scrutiny on the Draft Care and Support Bill*, May 2013, Cm 8627, pp [19–20](#))

In terms of the level of the cap, the Government's Impact Assessment on the proposal provides insight into how this figure was arrived at. It explained:

Setting the cap affects both the costs and benefits of the policy. In the current fiscal climate it is necessary to strike a balance between competing government spending pressures.

The major considerations in setting the cap were:

- The Commission on Funding Care and Support recommended that an appropriate level of cap in 2010/11 should be £25,000 to £50,000. It also said the cap should inflate over time so that every generation gets a fair deal.
- Cost of the policy. The amount of resources spent on the cap needed to be balanced against potential other uses for those funds and the Government's fiscal objectives.
- Sustainability of costs over time. The peace of mind benefits of the reforms rely upon people believing the reforms are sustainable over time and that they will be protected from unlimited care costs if they develop care needs. The lower the cap (and conversely the higher the cost of the reforms) the harder it would be to ensure that individuals believe successive governments will remain committed to this policy.
- The level of protection provided. A lower cap provides greater protection from unlimited care costs.

The proposal sets the cap at £72,000 in 2016/17 prices. In order to ensure that proposals were affordable and sustainable it has been necessary to go above the recommended range of the Commission with a cap equivalent to around £60,000 in 2010/11 prices.

Setting the cap at around £60,000 in 2010/11 prices provide people with protection from unlimited care costs and ensures that the policy is sustainable in the long term. The Government has set out how it will ensure that these reforms are fully funded for the next parliament. This funding commitment is vital to achieving the full benefits of these reforms.

([Social Care Funding Reform Impact Assessment](#), May 2013, IA No: 9531, p 12)

The Government has noted that because “most of the changes to these clauses are a result of new provisions to reform the funding system and create the cap on care costs” they were not scrutinised by the Joint Committee. However, “consistent with the recommendation of the Joint Committee, the regulations that set the level of the cap for the first time will be subject to the affirmative procedure” in parliament (ibid, p 20).

In its examination of the UK’s readiness for an ageing population, the [House of Lords Committee on Public Services and Demographic Change](#) was cautious about the Government’s proposed level of cap, observing that while the cap redistributed costs it did not provide an answer to a number of other issues. The Committee stated:

We consider that the Dilnot Commission’s proposals are far from a panacea for social care funding. The Government has estimated that the costs of their proposals in response to the Dilnot Commission will be £1 billion a year by the end of the next Parliament (ie 2020). The major gainers will be the relatively better-off, who will be protected from depleting their housing assets; and those who immediately gain will be the generation who have benefited from increases in housing wealth on an unprecedented scale over the past half-century.

The main advantages of the Dilnot Commission proposals were that they made clear to individuals the need to plan for the likely costs of long-term care, put a limit on the risks that individuals face, and would encourage the private insurance and pensions sectors to enter this market. The Committee considers that the Government’s response to the Dilnot Commission proposals is a welcome step in the right direction, and necessary, but it will not be sufficient. The proposals are primarily concerned with redistributing the costs of care. They do not bring extra funding into the system to tackle the current funding crisis, avert the tightening of eligibility criteria for care access, or address the problem of expanding need in the coming decades—although we acknowledge that this was not the task given to the Commission.

(House of Lords Select Committee on Public Services and Demographic Change, [Ready for Ageing?](#), 14 March 2013, HL Paper 140 of session 2012–13, Annex 11, paras 193–4)

The Government has said that funding social care remained a priority. Earl Howe told Peers in a debate that in 2013 “the NHS is transferring funds of £859 million to support adult social care services, which also have a health benefit. Alongside that, we have seen examples of local authorities redesigning services to find more efficient ways of using scarce resources” (HL *Hansard*, 14 May 2013, [col 387](#)).

However, the Association of Directors of Adult Social Services (ADASS) has described the current funding situation as “bleak and getting bleaker”. On 8 May 2013 it released the results of its annual survey of adult social care budgets. ADASS said:

The survey shows that, despite much welcomed resources being transferred from the NHS to local authority-funded social care, directors of adult social services are planning to save another £800 million in the twelve months to April.

Overall, in the three years since the beginning of the current austerity programme, some £2.68 billion savings will have been made by adult social care—20 percent of net spending. And although many of these savings have been achieved by increased efficiencies, social care leaders have been quick to point out that these efficiencies weren’t simple ‘back-office’ adjustments, but were gained by “providing different, more cost effective packages of care, or reduced levels of care, to many elderly or disabled people.”

The ADASS survey also revealed:

- Annual savings of 20 percent (£2.68 billion) of reductions will have been achieved by March 2014 from adult social care budgets; £795 million savings are planned for 13/14 on top of the £1.89 billion achieved in the last 2 years.
- Adult social care budgets remains at just over 1/3 of total council budgets (34 percent).
- Councils are reporting a demography pressure of 2.7 percent (£372 million) of ASC budgets in 2013/14. We believe that this figure is understated and is at least 3 percent of budgets (the figure identified in the last 2 budget surveys).
- Only 76 percent (£282 million) of calculated demography pressures have been funded by local authorities for 2013/14, compared with 82 percent last year.
- 82.3 percent of savings made in adult social care are through efficiencies (£651 million) compared with £688 million last year.
- 4.6 percent of savings are through increased income (£36 million) compared with £77 million increased income last year.
- The remaining 13 percent of savings are service reductions (£104 million) compared with £113 million last year.
- Eligibility thresholds within councils were only changed in three councils who increased their eligibility from 'moderate' to 'substantial'.
- 87 percent of councils have set their eligibility for 2013/4 at substantial or above.
- Only 37 councils (25 percent of councils) formally agreed with their respective PCTs a plan on how to spend the health re-ablement monies.
- Spend on prevention (£588 million) in 2013/14 represents only 4.2 percent of adult social care budgets.
- 45 percent of councils gave no inflation to older people's care homes in 13/14. 60 percent gave nothing for physical difficulties, 64 percent nothing for learning difficulties and 65 percent nothing for homecare.
- Of the £806 million reported as received by councils from the NHS Transfer in 2013/14 (out of a total of £859 million), 32 percent has been allocated to avoid cuts (£253 million). 14 percent allocated to cover demographic pressure (£113 million), 18 percent allocated for investment in new services (£140 million), and 36 percent has yet to be allocated (£291 million).

(ADASS, ['Social Care Funding: "A Bleak Outlook is Getting Bleaker"'](#), 8 May 2013)

## Protecting Individuals from Selling their Homes

The Bill contains provisions to prevent individuals having to sell their homes in order to pay for care. The Government has explained that this proposal will be the subject of consultation during the passage of the Bill:

Clause 34 provides for authorities to enter into agreements with individuals to defer payments payable to the local authority for chargeable services. Regulations may set out when authorities may or must allow someone to defer payment, what charges may be deferred, and any interest or administration fee that may be charged by the authority. We intend, through these regulations, to place duties on authorities to offer a deferred payment agreement to people going into residential care so that adults who would otherwise need to sell their home to pay for residential care may defer payment of reasonable care home fees. The introduction of this ‘universal deferred payment scheme’ will mean that people will not have to sell their home in their lifetime to pay for care. We plan to consult on the details of the scheme during the passage of the Bill.

(HM Government, *The Care Bill Explained—Including a Response to Consultation and Pre-legislative Scrutiny on the Draft Care and Support Bill*, May 2013, Cm 8627, [p 24](#))

The House of Lords Select Committee on Public Services and Demographic Change considered the issue of people selling their homes to fund care costs in its report *Ready for Ageing?* The Committee thought it reasonable for people to contribute to these costs by unlocking wealth they had in their property:

While understanding people’s emotional attachments to their homes, these properties are part of their economic framework and represent investments as well as homes. It is reasonable to expect those who have benefited from the property boom to support their own longer lives. We suggest that one way to address the current imbalance would be for more older people to consider unlocking housing wealth. Equity release could enable more people to use their assets to help pay for the cost of their social care, to adapt their homes, and to support their incomes. While equity release might impact on the inheritance of the children of wealthier parents and on people in areas where house values have increased most, older age still needs to be paid for. The Committee considers that it is right for those who have benefited from windfall gains to contribute to the costs of their longer lives through equity release, rather than for the full costs to be pushed to future generations.

(House of Lords Select Committee on Public Services and Demographic Change, *Ready for Ageing?*, 14 March 2013, HL Paper 140 of session 2012–13, annex 7, para [138](#))

## Care Standards

Part Two of the Bill contains the Government’s legislative response to the [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#).

On 6 February 2013 the Inquiry, led by Robert Francis QC, published its findings. It was established in 2009, following a report by the Healthcare Commission (HCC) in March 2009 and two reviews commissioned by the Department of Health. The Francis Report called for a system-wide response, across health and care, to ensure that the failures of Mid Staffordshire NHS Foundation Trust were not repeated. In total 290 recommendations for the commissioning, delivery, monitoring and regulation of healthcare were made with the aim, Mr Francis said, of “help[ing] Mid Staffordshire

NHS Foundation Trust and the wider NHS improve the safety and quality of care it provides to its patients” (ibid, p 4).

On 26 March 2013, the Government published its initial response, [Patients First and Foremost: The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry](#). Jeremy Hunt, in the foreword, said the Francis Report made “horrifying reading”. He continued:

At every level, individuals and organisations let down the patients and families that they were there to care for and protect. A toxic culture was allowed to develop unchecked which fostered the normalisation of cruelty and the victimisation of those brave enough to speak up. For far too long, warning signs were not seen, ignored or dismissed. Regulators, commissioners, the Strategic Health Authority, the professional bodies and the Department of Health did not identify problems early enough, or, when they were clear, take swift action to tackle poor care. They failed to act together in the interests of patients. This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again.

(ibid, p 5)

The Government said their response would be based on five points: preventing problems, detecting problems quickly, taking action promptly, ensuring robust accountability and ensuring staff are trained and motivated (ibid, p 15). In a statement accompanying the report’s publication, the Health Secretary said that:

The health and care system must change. We cannot merely tinker around the edges—we need a radical overhaul with high quality care and compassion at its heart...

I can pledge that every patient will be treated in a hospital judged on the quality of its care and the experience of its patients. They will be cared for in a place with a culture of zero harm, by highly trained staff with the right values and skills. And if something should go wrong, then those mistakes will be admitted, the patient told about them and steps taken to rectify them with proper accountability.

I and the chairs of key organisations involved in care have pledged to do this and make our health and care system the best and safest in the world.

(Gov.uk press release, [‘Government Publishes Initial Response to the Mid Staffordshire NHS Public Inquiry Report’](#), updated 26 March 2013)

In its notes explaining the Care Bill, the Government has said that “most of the measures within this [five point] plan focus on greater cohesion and cultural change across the system and can be implemented within the existing framework or can be achieved through secondary legislation—work on these changes is ongoing”. It said that it would also “publish a separate document that articulates more fully our vision for the regulation and oversight of NHS providers and how this will be realised”.

However, the Government has said that primary legislation was required, as there were “a further set of limited but significant measures that require adjustments to the system, primarily to the way health and social care information is used for assessment and to tackling poor performance. These changes are our key early priorities in responding to the Inquiry, and are needed at the earliest opportunity, through primary legislation” (HM Government, [The Care Bill Explained—Including a](#)



[Response to Consultation and Pre-legislative Scrutiny on the Draft Care and Support Bill](#), May 2013, Cm 8627, pp 35–6).

The Government explained these changes:

... will complement ongoing work being taken forward through secondary legislation and formulate a package that supports our five-point plan. Together, these changes will help bring about a revolution in the care that patients experience, rooting out unacceptable care, tackling failure promptly and effectively, and ensuring that the inspectorate and ratings framework inspires all hospitals to drive for continuous improvement.

Part 2 of this Bill takes forward a package of measures, the most significant of which focus on:

- requirements for the CQC to develop a system of performance reviews and assessments—a single version of performance that will allow organisations and the services they provide to be compared like for like in a fair and balanced way, that is meaningful to patients and the wider public.
- powers to allow the new Chief Inspector of Hospitals, appointed by the CQC, to instigate a new failure regime. This will mean that in cases where urgent changes are needed to address poor care or quality failings in NHS hospitals, this will be detected quickly, and there will be a clear and time limited process for intervening and tackling unresolved problems urgently.
- greater transparency and stronger accountability about the information providers produce on their own performance and outcomes, making it an offence for care providers to supply or publish certain types of false or misleading information and introducing additional legal sanctions.

(HM Government, [The Care Bill Explained—Including a Response to Consultation and Pre-legislative Scrutiny on the Draft Care and Support Bill](#), May 2013, Cm 8627, pp 35–6)

The Nuffield Trust, who were commissioned by the Government to conduct the review as to whether aggregate performance ratings would work in health and social care, issued a statement following the Government's announcement that 'Ofsted-style' ratings would be introduced. Nuffield Trust Chief Executive, Dr Jennifer Dixon, said:

The analysis we published in our review showed there is a clear gap in information for the public—too often patients and users of social care are left in the dark about the quality of health and social care.

Getting this right is no simple task though, and it will be a more complex challenge to introduce a single summary score for hospitals as Ofsted does for schools.

That doesn't mean it can't be done—just that there are many conditions that would be necessary to fully realise the benefits ratings could deliver. We therefore welcome the Government's recognition of the complexities involved.

Ultimately, the real prize is not finding a single summary rating for hospitals at large, but rather rating individual wards, departments and clinical services within hospitals as this is more likely to be of value to patients. We again welcome the Government's vision of making this a reality in hospitals up and down the country.



We will play our part in supporting the Department of Health, Care Quality Commission, professional and patient bodies and others in taking this forward.

(Nuffield Trust press release, '[Nuffield Trust: Response to Announcement on 'Ofsted-style' Ratings for Health and Social Care](#)', 26 March 2013)

### 3.3 Impact Assessments

Alongside the Bill the Government has published ten impact assessments, covering different aspects of the Bill. These can be accessed on the [Gov.uk](#) website.

A summary document provides an overview of each impact assessment:

A summary of costs to the public sector (but not costs to business), and corresponding benefits, arising from the Care Bill are shown below. Figures are given in the terms of present value, which represents costs or benefits over 10 years discounted for the future.

	Impact assessment	Public sector costs (present value) (£ million)	Benefits (present value) (£ million)
<b>Part 1</b>	Funding reform	12,370	14,760
	Legal reform	-1,301	10,015
	Deferred payments	112	366
	Market oversight	10	108.1
<b>Part 2</b>	Failure	Non-monetised	Non-monetised
	Ratings	Non-monetised	Non-monetised
	False and misleading information	0.7	Non-monetised
	S19 loophole	0	Non-monetised
<b>Part 3</b>	HEE	0	Non-monetised
	HRA	0.068	Non-monetised

([Care Bill: Impact Assessments—A Summary and Overview](#), May 2013)

## 4. Comment and Reaction to the Bill

### 4.1 Queen's Speech Debate: House of Commons

On 13 May 2013 the House of Commons debated the health and social care aspects of the Queen's Speech. This gave MPs the opportunity to discuss, among other issues, the Care Bill.

For the Opposition, Andy Burnham (Labour) said that "at face value, the social care measures that the coalition is proposing sound like progress towards a fairer and simpler system". He said that "the Care Bill builds on many of the recommendations of the Law Commission's review of adult social care legislation, which was initiated by the last Government and included in the White Paper I

published before the last election”. The inclusion in the Bill, he said, of “national standards for eligibility could help to bring consistency to the care system, and stronger legal rights for carers are long overdue, as is improved access to information and advice”.

Mr Burnham thought that MPs needed to consider that “the question in the minds of many today, particularly councillors watching this debate, will be: how on earth will we be expected to pay for all that? That is when we realise again that there is a huge gap between the rhetoric we hear from the Dispatch Box and the reality on the ground across England. More than £1.3 billion has been cut from local council budgets for older people’s social care since this Government came to power”.

He criticised the Bill for doing “nothing for people who face a desperate daily struggle to get the support they need right now, with many paying spiralling charges for their care. That is the effect of this Government’s drive to cut councils to the bone. They are foisting huge care charges on the most vulnerable people in our society. These are the coalition’s dementia taxes”. He added:

The Care Bill does nothing for those hit by the coalition’s dementia taxes right now. Since this Government came to power, the average care user has paid £655 a year more for home care than when they came into office. Overall, that is around £6,800 a year. Dial-a-ride transport services have doubled in price over the same period, from an average of £1.92 to £4.12. Meals on wheels now cost an extra £235 a year, while people in Conservative areas pay more for each service on average than friends and family in Labour-controlled areas—on average, £15 a week or £780 a year more for home care. That is the record of this Government.

(*HC Hansard*, 13 May 2013, [cols 355–9](#))

Paul Burstow, the former Care Services Minister, welcomed the Bill and reminded MPs that it was “essential that in considering this over the next few months we make sure that we get it right, because legislation in the social care sphere comes to the House very infrequently” (*ibid*, [col 368](#)). In spite of his support, Mr Burstow said there remained some questions about certain aspects of the proposals. He explained:

First, some serious questions remain about how the Bill, which we will scrutinise over the coming months, will deal with the issue of young carers, which has already been raised. It is possible that young carers will fall into a gap between the Children and Families Bill, which is currently before the House, and the Care Bill, which will soon be before us. The Care Bill needs to address situations in which an adult does not qualify for local authority support and their children end up taking on caring responsibilities that become overly burdensome and inappropriate. In such circumstances the adult should be entitled to some sort of service so that their child does not lose their childhood to caring responsibilities. That requires action in the adult-related Care Bill; it should not be pushed away to be dealt with in the Children and Families Bill.

The second issue is poor commissioning practice, which was highlighted by an Equality and Human Rights Commission report on home care more than 18 months ago. It identified that contracting by the minute, or time-and-task contracting of home care, denigrated people and that they were being dealt with in an undignified way as a consequence of how services were being commissioned. Just a few weeks ago the Low Pay Commission’s most recent report highlighted, yet again, too many circumstances in which home care is being delivered by people who are paid below the national minimum wage. That is unacceptable and the Government need to deal with it.

(*ibid*, [cols 369–71](#))

He concluded by also raising the subject of funding. He explained: “the spending review that is under way is for just 12 months. It needs to fund the successful implementation of this legislation, and not least the introduction of the Dilnot proposals. More than 450,000 people will need assessments to get into the new system. The spending review also needs to sustain the transfers of money from the NHS to social care. Beyond that, the spade work needs to be done now to make the case for the critical interdependencies between social care and health that will sustain our social care system and make our health system deliverable and affordable (ibid).

Barbara Keeley (Labour) added her concerns about the Bill’s lack of provisions relating to young carers. She told MPs that “the picture of provision for young carers is now very confused, and it is a priority for Parliament to sort it out”. She claimed that amendments to the Children and Families Bill with this intention were being resisted by the Government, saying it was “not good enough to have this partial recognition of young carers in the Care Bill or to have the Children’s Minister rejecting cross-party amendments on provision for young carers”. She added that the Minister for Care Services had “said several times that he wants a single statute. If that single statute is the Care Bill, it has to deal with young carers properly. It is plainly wrong that it does not” (ibid, [cols 375–6](#)). She concluded that she welcomed “the steps being taken in the Care Bill, but it must be strengthened and improved in the ways I have outlined, because things such as assessments are not very helpful for carers and young carers, if that is all we are offering” (ibid, [col 378](#)).

Robert Walker (Conservative) was pleased by the proposals for a cap. He said that “by setting a cap, albeit a higher one than many of us would have liked, the Bill will start the process of ensuring that nobody has to lose their home to pay for care. Setting a cap at any level should help the insurance industry to create products that protect thousands more people from that risk. The threshold... is key and will ensure that thousands more people are helped by the Government than would have been the case without the legislation” (ibid, [cols 424–6](#)).

Closing the debate, Norman Lamb, the Care Services Minister, said that it was “hard to exaggerate just how badly the Care Bill is needed”. He said that previous legislation was “now hopelessly outdated and almost irrelevant to the needs of today’s society. Tinkering around the edges was keeping the system afloat, but no more than that”. He added that the Bill was a “big social reform—one of which this coalition Government should be proud”. He argued:

The new Care Bill will reform an antiquated, paternalistic system, improve people’s experience of care and establish both health education England and the health research authority as non-departmental, stable, independent public bodies. The Bill will pool together threads from more than a dozen Acts into a single, modern framework for care and support, but it is far more than a mere compilation. The Bill will fundamentally reform how the system works, prioritising people’s well-being, needs and goals, so that they no longer feel they are battling against the system to get good care.

(ibid, [col 462](#))

He concluded:

It is this coalition Government who have bitten the bullet on a very important reform. I am very proud of the fact that we are doing this, introducing a long overdue reform. Andrew Dilnot himself has strongly supported the Government’s action. That is happening together with a very significant extension of support...to help people of modest means with their care costs. Each one of those measures would be significant by themselves. Together, they provide real optimism that we can shake off the shackles of the past and look towards the future, not with fear, but with optimism. The Opposition are wrong to dismiss the importance of this Bill.

They should recognise just how much it could improve the lives of some of the most vulnerable people in society.

(ibid, [col 464](#))

## 4.2 Reaction Outside Parliament

A number of organisations involved in adult social care have issued responses to the introduction of the legislation.

The Social Care Institute for Excellence (SCIE) said it was a “very welcome and important Bill that will strengthen the sector’s responsibilities and capacity to improve care for people who use services and their carers”. Andrea Sutcliffe, Chief Executive, in a statement said that:

In particular, SCIE welcomes the new emphasis on: care that prevents crises developing; the assessment of children’s needs to help them with the transition to adults’ services; and safeguarding adults.

SCIE will work with the Department of Health, the care sector, people who use services, and carers to help to identify the most effective ways of delivering the changes required.

(SCIE press release, [‘The Care Bill 2013–14’](#), 10 May 2013)

The Local Government Association (LGA) said it had supported the Law Commission’s review and was “therefore pleased to support the principle of a single legal framework. This will give greater clarity to legal entitlements to care and support”. The LGA added that it was “committed to supporting a care and support bill passing into law in order to achieve the reforms so urgently needed”. Its statement added however that sufficient funding was needed:

- While a move towards ensuring carers receive better support is a positive step, neither carers or councils can manage in a chronically under resourced system. Local authorities are already facing an estimated £1.89 billion reduction in social care funding and we would urge government to ensure that any additional support is properly funded.
- A fundamental difficulty with the proposals is that both the White Paper and the Draft Bill have detached policy direction and decisions from financial direction and decisions. The overall context in which the draft Bill is being considered—the Government’s austerity programme and the need for further savings—does not fit well with the aspirations of the Bill.
- We fully support those aspirations but without a clear commitment from Government on funding for social care these will simply not be realised.

(LGA press release, [‘Queen’s Speech—On-the-day Briefing’](#), 8 May 2013)

In its statement the Care and Support Alliance welcomed the announcement of the Care Bill in the Queen’s Speech. However, it too raised concerns about funding, saying:

The care system is vastly underfunded and, if it is to succeed, the Bill will need to be accompanied by suitable funding commitments in the June 2013 Spending Review. The CSA hopes that the Bill and regulations, together with appropriate funding, will deliver a social care

system that prioritises wellbeing, ensures people receive the information, support, advice and advocacy they need, adopts a preventative approach to care, provides for carers, includes a national eligibility threshold that allows for wellbeing and prevention, and delivers true portability of care.

(Care and Support Alliance, [‘Briefing for the Debate on the Queen’s Speech’](#), May 2013)

Michelle Mitchell, Charity Director General at Age UK, said that the proposals had “the potential to transform our crumbling, unfair social care system for current and future generations of older people, but to have any chance in succeeding we need to see the legislation twinned with a commitment in the spending review for increased spending on social care”. She argued that since the general election 2010 “in real terms £710 million has been cut from social care spending, mostly as a consequence of the slashing of local authorities’ budgets at a time when need is rising due to our ageing population”. She expressed concern about the implications of this funding gap:

In the vast majority of councils now only those assessed as having substantial care needs are able to access the current system and unless the Government sets the proposed national eligibility criteria at the equivalent of moderate, hundreds of thousands of people who cannot carry out everyday tasks such as washing, getting dressed, preparing food and laundry will be left without help.

If people purchase their own care in order to meet needs assessed as ‘moderate’ this will not count towards the £72,000 cap introduced by the Government. People could be dissuaded from getting help at just the stage when social care support could make a real difference.

Good care makes good sense. If older people get good quality care at home it helps them remain independent for much longer, helps keep them out of hospital and protects families from the pressures of caring.

(AgeUK press release, [‘Age UK’s Response to the Queens Speech’](#), 8 May 2013)

Responding to the Care Bill on behalf of Macmillan Cancer Support, Mike Hobday, Director of Policy and Research, welcomed the Bill. He raised the issue of carers of cancer patients:

We can no longer turn a blind eye to the fact that the current system of identifying and signposting carers to support is failing. Only 5 percent of the estimated 900,000 people currently looking after someone with cancer in England have had a carers’ assessment by their local authority which gives them access to vital support. Without this, many cancer carers could suffer with physical and mental ill-health and struggle to cope with the demands of their role.

However it’s not just councils that need to identify cancer carers, the NHS must play a key role too, as they often come into contact with them first via the person with cancer.

As cancer is no longer necessarily a death sentence, this means there is a growing need for people to care for a loved-one with cancer. We are urging the Government and NHS England to review the current system so cancer carers now and in the future are not left completely isolated.

(Macmillan Cancer Support press release, [‘Macmillan Cancer Support Responds to the Care Bill Announced in the Queen’s Speech’](#), 8 May 2013)

The Alzheimer's Society welcomed the potential of the Bill but pointed out the importance of the eligibility criteria and that funding was needed to support the policy. Its statement said:

We all hope for a happy, healthy retirement but the reality for tens of thousands of people with dementia is very different. Too many people are being forced to struggle without the support they need—help with getting up in the morning, eating their meals and living with dignity. For the people who can get support at all, the costs can be astronomical.

Today's Bill has the potential to bring about important changes to prevent the highest costs, integrate care and give carers the recognition they deserve. However we must ensure eligibility levels are not set so high as to deny thousands of deserving people vital support. Also unless the huge financial hole in the social care system is addressed in the summer's spending review, the system will never be fully fixed.

(Alzheimer's Society press release, '[Alzheimer's Society Response to Care Bill Publication](#)', 10 May 2013)

The Royal National Institute for the Blind (RNIB) welcomed the announcement of the Care Bill. In its comments on the Bill, the RNIB feared though that “without adequate funding, this will deliver very little change in the fortunes of blind and partially sighted people who need care and support”. It said that it would “join with the Care and Support Alliance members in calling on Government to adequately fund the new arrangements set out within the Bill—in the spending review for 2015/16 taking place on 26 June 2013”. The RNIB added that the “key areas” that needed prioritising were “the Bill to deliver for blind and partially sighted adults” were “re-ablement; assessments and eligibility”. It continued:

Other proposals on a right to assessment for carers are of course welcome but access to care and support is the critical issue for people with sight loss when there has been a reduction in the numbers accessing the system in recent years. Since 2005 the number of blind and partially sighted adults receiving social care services has dropped by 36 percent, compared to an average 16 percent drop for all adults.

(RNIB press release, '[The Royal National Institute of Blind People \(RNIB\) Responds to the Queen's Speech](#)', 8 May 2013)

Head of Public Policy at Sense, and Vice Chair of the Care and Support Alliance, Sue Brown, said the Bill “was a welcome step forward in starting to address some of the huge challenges the social care system faces. In particular, we welcome the Bill's greater emphasis on promoting an individual's wellbeing. We hope this expanded definition of wellbeing since the Draft Bill—including physical and mental health as well as being able to make a contribution to society—will help deafblind people to live fulfilling lives as active members of society”.

Ms Brown added that:

Sense is also hopeful that the Bill will mean the current provisions of the Deafblind Guidance will be kept. This means that local authorities will have to carry out assessments by someone who has expertise in the needs of deafblind people. Our report last year showed that nearly half of people (49 percent) were still trying to get a specialist assessment or had not found it easy to receive one. We hope that the Bill will remove these unacceptable barriers and enable deafblind people to receive the assessment and support they may be legally entitled to.

It is clear that to solve the social care crisis, there also needs to be much greater funding of social care. Without increased funding, we would question how far the reforms in this Bill will be realised.

(Sense press release, '[Sense Response to the Publication of the Care Bill](#)', 10 May 2013)

Heléna Herklots, for Carers UK, stated that the Bill marked “a further and significant step forward in the rights of families who care for older or disabled loved ones; improving access to an assessment of carers’ own needs and new duties to support families who care”. She also added her voice to those concerned about funding:

To make these rights a reality for families, in addition to ensuring that all carers have equal rights, whether they are caring for a parent with dementia or a disabled child, Government must also take action on the chronic underfunding of social care services.

The Bill needs a robust funding settlement which enables the Government to realise the vision that is set out in this landmark legislation. Without this kind of investment, the new legislation will fall short of its potential, leaving many families struggling without the right support and giving up work to care.

(Carers UK press release, '[Carers UK Hails Success as Bill Moves towards Landmark Rights for Carers](#)', May 2013)

In its statement the Association of British Insurers referred to the importance of “appropriate and regulated” financial advice for those accessing care:

We support the Care Bill’s objectives of improving and simplifying the social care system into a single framework, and introducing the recommendations of the Dilnot report on care funding. The Bill is a major step forward in the development of a social care system fit for the future, and we look forward to working with Government on how the new model can be implemented. This must include how people can be given appropriate and regulated financial advice to support their decisions.

We also need a national campaign to raise awareness of the State’s offer and that people need to plan for their care needs. This needs to be considered alongside the Bill to help us move towards a more financially resilient society.

(Association of British Insurers press release, '[ABI Responds to Care Bill](#)', 8 May 2013)