Free personal care in Scotland

Recent developments

David Bell, Alison Bowes and Alison Dawson

This report examines the operation of the free personal care policy in Scotland, and considers its impact, problems and limitations.

Looking primarily from a local authority perspective, the study suggests possible reasons for increases in demand for care. Although the policy has wide public support, local authorities report that misunderstandings remain, for example, concerning whether meal preparation is free.

The study also investigates why there is so much variation between local authorities – some controlling expenditure successfully but others having difficulty meeting the costs of the policy.

The study is based on analysis of statistical data since 2002 and on a series of interviews conducted from August to October 2006 with local authorities and the Scottish Commission for the Regulation of Care.

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Contents

Acknowledgements vi

Executive summary vii

1 Introduction 1

2 Local authority experiences 2
Introduction 2
The context of care in Scotland 2
Impacts of free personal care 4
Problems and perceived problems with the free personal care policy 17
Perceived limitations to the policy 22

3 The bigger picture: statistical analysis 26
Introduction 26
Changes in demand for personal care since 2002 26
Heterogeneous local authorities? 36
The costs of the policy 47
An example of good practice 50

4 Conclusions and implications 52
The demand for care 52
The delivery of care 52
Perceptions of free personal care 53
The impact on local authorities 53
Implications 54
Conclusion 56

Notes 57

References 61

Appendix: Research methods 63

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Executive summary

This study updates research by Bell and Bowes (2006) on financial care models in the UK, focusing on the position in Scotland and in particular on the operation of the 'free personal care policy'. The free personal care policy, implemented in July 2002, is particular to Scotland. It provides that, where a person has been assessed as having personal care needs, then personal care services provided by the local authority to meet those needs will be free of charge.

This report presents and discusses perceptions of the context of care in Scotland and the perceived impacts of, problems with and limitations of the free personal care policy. It examines these issues primarily from a local authority perspective. It is based on analysis of statistical data since 2002 and on a series of interviews conducted during August to October 2006 with 11 Scottish local authorities and with the Scottish Commission for the Regulation of Care.

Key findings

The demand for care

- There has been a Scotland-wide increase in demand for care at home. Between 2002 and 2005 there was a 10 per cent increase in the overall number of local authority home care clients. Within this group, the number receiving personal care increased by 62 per cent.

- This cannot be explained by demographic trends, higher rates of disability or reductions in informal care. Movement of costs from health to social care and the emergence of unmet need have contributed to increased demand.

- Attempts (under the delayed discharge policy)[1] to reduce numbers of older people staying in hospital once inpatient treatment is no longer necessary may have moved some costs from health care to social care but these are difficult to identify.

- The emergence of unmet need from those who were not previously local authority clients may have increased demand for care at home.

The delivery of care

- Changes in the behaviour of informal carers in terms of the services they provide to care clients may go some way towards explaining the increase in demand for care at home. There are indications that informal carers are delivering less personal care and more care of other kinds.

- There is some qualitative evidence that free personal care is changing informal care. Informal carers may be substituting other forms of care and support for personal care tasks where these are provided without charge by the local authority. This effectively increases the amount of care that an older person can receive and also supports carers in their caring.

- Statistical data indicate no withdrawal from informal care. However, there are no systematic data available on what tasks informal carers actually do and on the choices that may be made in the context of the availability of free personal care.

- There is a widely reported trend towards increases in the private sector provision of care at home, permitting speed and flexibility in service delivery, as well as filling gaps in supply resulting from increased demand.

- Choice and control for service users have been increased by greater flexibility for informal carers and the increased range of providers, as well as by the availability of free services.

Perceptions of free personal care

- Local authorities report that free personal care is still not widely understood. Members of the public and elected members frequently take it to mean that all care is free and this leads to complaints about legitimate charges, including 'hotel'[2] charges.

- There has been persistent confusion over which tasks associated with meal preparation should be regarded as personal care tasks and therefore provided without charge. This issue is the focus of potential court action. Local authorities reported that there is still significant uncertainty as to how charges should be levied for some tasks and several reported that they would welcome a judicial decision to guide their actions.

- The free personal care policy is perceived to have benefited many older people with care needs, but also to have either directly or indirectly disadvantaged certain groups. It is widely regarded as inequitable and discriminatory in limiting eligibility to those aged 65 and over with care needs. Budgetary constraints experienced by authorities are seen as limiting further community care service development for other client groups.

- Recent evidence on public opinion (2005 Scottish Social Attitudes Survey)[3] shows that 59 per cent of Scots believe that personal care should be paid for by Government and 68 per cent would pay an extra 1p in the pound income tax to finance spending on personal care.

The impact on local authorities

- There is continuing very significant variation between local authorities, and developments are inconsistent across the country, with some authorities apparently increasing overspends and others controlling expenditure more successfully.

- The particular situation in each local authority depends on a culmination of previous decisions on care policies. Under the free personal care policy, authorities faced new expenditure. The impact of this varied according to previous charging practices. For example, where authorities had not previously charged for personal care, the financial impact of the policy was not large. Where authorities had received large amounts of money from chargeable[4] clients, the impact of the new calls on their budgets was greater.

- Nearly all local authorities report that they are underfunded for the delivery of free personal care. They welcome the fact that evidence of numbers receiving personal care is now emerging. Prior to the introduction of free personal care, personal care was not distinguished in data collected by local authorities and the Scottish Executive, and its costs could not therefore be ascertained.

- Nevertheless, variations in spending now provide evidence that some local authorities have had more success than others in controlling expenditure, and yet performance indicators show that they can continue to deliver high-quality services. There is evidence that whole system reform at local authority level can contribute to success in this area.

Key conclusions and implications

- The present study sheds light on the consequences for local authorities and service users of delays in addressing repeatedly identified problems with the implementation of the free personal care policy.

- Data collection issues need to be addressed. Statistical data about the provision of free personal care in the context of the wider universe of care provision are now starting to appear. It is imperative to set out clearly what such data should cover and to collect data systematically in order to reduce local authorities' uncertainty in completing returns, facilitate robust analysis and provide a new baseline from which future monitoring and analysis can proceed. Attention should be focused on the key indicators of demographics, disability rates and overall costs.

- The spend and quality of services delivered need to be reviewed at local authority level. A review of spend and quality of services at local authority level could draw on other practice where high-quality services are evident alongside lower levels of spend.

- It is important for good practice to be identified and for lessons to be shared and implemented by all local authorities. Some authorities are able to provide high-quality services with low relative expenditure. With demand for care at home increasing since the introduction of free personal care, it is in the interests of both local authorities and service users that all authorities understand how this can be achieved and where possible emulate best practice elsewhere.

- The quality of available information on the free personal care policy needs to be improved. Local authorities, service users and the general public could all benefit from clearer guidance and sufficiently detailed information to develop a fuller understanding of what the policy entails.

1 Introduction

This report updates research commissioned by the Joseph Rowntree Foundation on financial care models in the UK.[1] Fieldwork for the earlier research took place towards the end of 2004 and the findings were published in February 2006. This extension to that evidence has a far narrower remit. It focuses on the position in Scotland and examines the continued operation of the 'free personal care policy' primarily from a local authority perspective.

The free personal care policy was implemented in July 2002. It relates to the provision of care to people aged 65 and over. It provides that, where a person has been assessed as having personal care needs, then personal care services provided by the local authority to meet those needs will be without charge. Additionally, where a person with assessed care needs is resident in a care home, the local authority will make a contribution to their personal care costs and, where eligible, to their nursing costs. The rate of local authority contribution was set in July 2002 and has not altered. Care home residents eligible for payments receive £145 towards personal care and £65 per week for nursing care. There is no specified amount for the costs of care provided at home.

This report presents findings from qualitative research and from quantitative analyses. The qualitative findings are drawn from interviews with 11 Scottish local authorities and with the Scottish Commission for the Regulation of Care (the 'Care Commission'), the key regulatory body for care provision in Scotland. The quantitative analyses both describe the broader context of care in Scotland and provide explanatory insights into aspects of the operation of the free personal care policy. The qualitative research methods and data and statistical sources used in the quantitative analyses are described more fully in the Appendix.

2 Local authority experiences

Introduction

This chapter explores findings from the interviews with local authorities and with the Care Commission. These are presented in four sections.

- The first of these, 'The context of care in Scotland', provides local authorities' views on the policies and processes that overlap and overlay free personal care. It covers such issues as the use of Single Shared Assessments (SSAs), policies to reduce delays in discharges from hospital care, and the changing relationship between health and social work professionals.

- The second section discusses the impacts and perceived impacts of the policy, subdividing these into direct and indirect impacts. The former include perceived increases in budgetary pressures and labour force issues, with the latter encompassing changes in informal care and in complaints to local authorities.

- The third analyses the problems and perceived problems with the free personal care policy from a local authority perspective. These include difficulties related to different stakeholders' understanding of the substance of the policy and to data collection.

- The final section examines local authority perceptions of the limitations of the free personal care policy.

The context of care in Scotland

- The free personal care policy was introduced at a time when significant changes were being made to other aspects of community care.

- Many initiatives, including Single Shared Assessment processes and Community Care Partnerships, are part of a broader policy objective of developing more 'joined-up' care services.

- Others, such as the policy on delayed discharges from hospitals and the free personal care policy itself, can be seen as part of an increasing emphasis on care in the community.

An assessment of needs is a prerequisite for eligibility for free personal and nursing care. Increasing demand for assistance under free personal care had led to increasing numbers of assessments. This has focused more attention on issues such as the assessment process and the interactions of different agencies involved in the management and delivery of care services. Single Shared Assessment (SSA),[1] the development of which predates the free personal care policy, necessarily interacts with the policy because of the need for assessment. SSA also brings into relief the difficulties inherent in developing more 'joined-up' services.

Although widely implemented, SSA was said to be still evolving in most local authorities. Social care services were perceived by interviewees in some local authorities to be more committed to the process of Single Shared Assessment than their health colleagues, with social workers carrying out more assessments. Where there was collaboration with health services, it was noted that health service assessments tended to be less comprehensive than those carried out by social work personnel. Thus assessments for free personal care continued to be more likely to be made by social workers. One consequence of this is that the additional assessment burden that arose in most local authorities as a result of stimulating demand for service via the introduction of free personal care is being serviced primarily by local authority social work services, even where joint working processes have been established.

There are some boundary disputes between health and social care services concerning which budget should cover some items – helping older people to put on pressure stockings was given as an example. This can be difficult for the individual and assistance with putting stockings on could be considered as either a 'personal care' task or as a 'health' task, depending on exactly why the stockings are to be worn. There is no significance to service users in designating tasks as primarily 'health' or 'personal care' related, but the designation determines who assists them and whose budget bears the costs. These tensions are not new, but are increasingly common when the numbers of older people with complex care needs receiving care at home are increasing. Where they occurred, issues such as this were presented as symbolic of pressure on budgets in both health and social care.

The interviews explored the impact of Community Health (and Care) Partnerships (CHPs).[2] CHPs are committees or sub-committees of a health board. The Statutory Guidance makes clear that the role of CHPs includes co-ordinating the planning, development and provision of particular health services with a view to service improvement. One aspiration is that CHPs should support further moves towards collaboration between health and social care services. The original implementation date for CHPs was from April 2005 (although some were operating in shadow form

prior to that date). As at May 2006 most were in place, although delays in finalising the CHP schemes of establishment in some NHS health board areas had occasioned delays beyond this date.[3] Our interviewees noted that health services found such collaboration particularly difficult and in some cases did not co-operate effectively with local authority social work services – for example, telling hospital patients what care they would receive at home before assessments had been conducted. In some areas, where there had been a history of joint working, the CHPs were described as working more successfully. Free personal care was said to have highlighted some of the difficulties in joint working, though not to have been responsible for them. This may relate back to the transfers of resources that accompanied activity on delayed discharge.

Delayed discharges occur when patients ready for discharge cannot leave hospital because the other necessary care, support or accommodation for them is not available. Older people are especially vulnerable to delayed discharge. 'Resource transfer' was supposed to have taken place following the introduction of the care in the community policy. The intention was that NHS boards would transfer resources saved by the closure of inappropriate continuing care beds to local authorities to enable them to develop and provide services in the community for older people. However, a 2002 report on delayed discharge in Scotland[4] found that determining the size and timing of resource transfer had been a cause of dispute and ill-feeling between local authorities and health boards, and that there was evidence that not all the resources saved had been transferred to local authorities for reinvestment in community services for older people.

Impacts of free personal care

Direct impacts

Financial impact of the policy

- The immediate financial impact of free personal care varied across authorities and depended on factors such as local levels of affluence and local authority decisions prior to the introduction of free personal care on care-related policies, including charging policies.

- Most authorities reported experiencing current pressures on budgets for the care of older people arising from the costs of providing free personal care.

- The majority of authorities feel that they are underfunded because their spending on free personal care has exceeded the indicative amounts for spending on the policy contained in their Grant Aided Expenditure (GAE) allocation from the Scottish Executive.

There has been a 62 per cent increase in the provision of free personal care at home and a 29 per cent increase in care home provision during the first three years of the policy. Nearly all the authorities suggested that they were experiencing funding pressures on budgets for community care and for the care of older people, though it was not always possible to link these with free personal care. Some of these pressures clearly resulted from demographic changes or wider policy shifts. Nevertheless, increased demand for free personal care was seen as putting extra pressure on limited resources. The causes of increased demand are complex, and may include the emergence of unmet need as well as changes in the tasks that informal carers perform. However, as we will discuss in Chapter 3, local authorities have varied significantly in their ability to meet increased demand, while controlling (or not controlling) costs.

For some authorities, the impact of free personal care had not initially been great. These authorities tended to have charging policies prior to the introduction of free personal care that provided home care services to all service users for free or at greatly subsidised rates. In some cases, low levels of affluence in the local population meant that some authorities had been providing home care services without charge to most service users irrespective of their charging policies. These local authorities did not experience the immediate surges in demand or the large losses of income apparent in local authorities with generally more affluent populations. They experienced a more gradual increase in demand since the implementation of free personal care, bringing a more gradual increase in costs. In some authorities with initial control of expenditure on free personal care, budgetary control was becoming increasingly difficult. One authority had undergone a major reorganisation in anticipation of increased demand arising from particular local demographics, and had found this beneficial in meeting the additional increase in demand for free personal care.

There appears to be a continuing 'stand-off' between local authorities and the Scottish Executive in relation to the GAE (Grant Aided Expenditure)[5] allocations, in which free personal care has been highlighted as a key element. For forward planning purposes, notional GAE allocations are calculated in advance for a three-year period using base calculation data and projections. These are subject to changes because of policy matters arising in the interim, but provide local authorities with an idea of how much the Scottish Executive anticipates that they will need to

spend on different services. Figures within the published GAE allocations provide local authorities with an indication of how much they will need to spend to fulfil their obligations in relation to the free personal care policy.

Most authorities claim that they are underfunded because their spending on free personal care has exceeded, and they anticipate will continue to exceed, the indicative amounts for spending on the policy contained in the GAE. As a result of spending levels, local authorities suggest that they are having difficulties meeting the costs of the free personal care policy. One authority noted that, though the GAE allocation had increased locally, all the extra resources were being used to deliver free personal care. Some authorities have spoken directly to the Scottish Executive about the apparent mismatch between GAE allocations and their spending on free personal care but feel that, to date, Scottish Executive responses have been insufficient. We will show in the section on 'Heterogeneous local authorities?' in Chapter 3 that GAE allocations explain some of the difficulties experienced by some local authorities, but that, in other cases, increase in GAE has outstripped the increases in demand.

Through its inspection role the Care Commission has noted evidence of pressure on local authority budgets. However, at least one authority interviewed also highlighted expenditure on children's services as exerting heavy pressure on funding. One authority also noted that there was some competition between local authorities in this debate, arguing that, if GAE was redistributed, there would be well-known winners and losers. In response to this, other local authorities suggested that a larger allocation for older people's services, including ring-fenced elements, would be an appropriate solution. Most authorities had introduced eligibility criteria for care services as a major plank in their short-term resolution of the problem of underfunding, but looked to the Scottish Executive to reconsider allocation formulae and, most critically, to increase the overall funding available for free personal care in the longer term. Available statistics do indeed demonstrate increased costs, but also marked variation among local authorities in their ability to control spending.[6]

Some authorities gave specific examples of what they felt were cross-subsidies from other budgets towards free personal care. However, it was also noted that, in the past, older people's services had been a lower priority and other services might have received cross-subsidies. Children's services were specifically highlighted in one case and Supporting People in another. There was no overall consensus as to the desirability of ring-fencing budgets for older people's care.

The question of finance for the free personal care policy has recently been considered as part of the Scottish Parliamentary Health Committee's Care Inquiry.

In its *Care Inquiry Final Report*, published in June 2006,[7] the Health Committee concluded that there were a number of problems identified with the implementation of free personal care for older people, including 'questions about the funding formula put in place by the Scottish Executive' (paragraph 64).The Health Committee recommended that, to address this issue:

> The Scottish Executive should undertake a thorough review (based on the experience of the last 3 years) of the resources required by local authorities, collectively and individually, to adequately finance free personal care. This may require an increase in funding, or more equitable distribution amongst local authorities
> (Health Committee Care Inquiry Report, para. 66)[8]

The Scottish Executive's response to the report[9] set out the actions that the Executive intended to take in response to the Health Committee Care Inquiry Report. In relation to the specific recommendation concerning funding of the policy contained in para. 66, the Executive stated:

> We accept the Committee's recommendation. At present, the allocation of money for personal care at home is provided on the conventional basis which takes into account the population of older people in each local authority area; and money for personal care in care homes is allocated separately on the basis of the number of people in care homes paying their own fees. However, the Executive is currently working with COSLA and the Three Year Settlement Group to agree a new statistical formula for the distribution between local authorities of funding provision for free personal and nursing care in care homes in time for the 2008–11 settlement.
>
> The current policy evaluation includes a review of the cost of the implementation of free personal care. The outcome of this work, along with the findings of the evaluation, will help to ensure that future cost projections for the policy are based on accurate information, and that financial allocations to councils are distributed effectively.[10]

Providing care

- Most local authorities have increased the volume of private and voluntary sector care that they purchase to meet increased demand.

- Free personal care is perceived to have accelerated the pre-existing trend towards a mixed economy in care services provision, but private sector growth is said to be concentrated in areas of higher population density.

Local authorities started from different bases in terms of the percentages of home care services provided in-house prior to the introduction of free personal care. Nevertheless, most have increased the volume of private and voluntary sector care that they purchase to help cover expanding client bases and increased demand in terms of number of hours of care. Supplementing in-house provision was seen in most cases as a pragmatic response to higher numbers of service users, service availability and cost issues rather than efforts to stimulate the mixed economy, although many local authorities believed that mixed care provision offers greater flexibility. For example, private sector providers have been used to provide immediacy of service where putting care packages in place using in-house resources is difficult in the short term because of client remoteness and/or staffing issues. The Care Commission's belief was that local authorities generally provided services in-house during the daytime hours on weekdays and were more likely to contract out to the private sector weekend and out-of-hours services, which they found more difficult to provide. One authority suggested that this was largely the case in their area because of 'traditional' local authority employment contracts, but that they, like many authorities, were in the process of renegotiating terms and conditions with care services employees.

There was evidence of a trend towards a mixed economy in the provision of care services in Scotland prior to the implementation of free personal care. Most interviewees felt that the policy had increased this trend, although those in local authority areas where rurality and service user dispersal are greatest reported that the development of a private home care sector had stalled in areas of low population density. Local authorities felt that they had been forced, at least partly because of the increased demand as a result of the free personal care policy, to supplement in-house provision. This had fuelled private sector expansion in some areas, but interviewees suggested that the private and voluntary sectors had been developing in those local authority areas prior to this. The expanded availability and use of private and voluntary care providers has brought extra benefits to some service users in terms of flexibility and speed of service provision, and is thus a positive (though possibly unforeseen) outcome of the free personal care policy.

Most authorities suggested that there was, and to an extent still is, a price differential between in-house services and those purchased from the private/voluntary sectors, although the gap was perceived to be narrowing. The private sector was perceived

as having lower unit costs because employees are less well trained and less well paid, and because private sector employers do not provide employees with the same learning and development opportunities as the public sector. That said, a number of authorities reported having developed closer working relationships with local providers and there was an increasing expectation that private and voluntary sector organisations would deliver to the same standards and within the same pricing structures adopted in-house. Interviewees believed that, from service users' perspectives, these developments can only be helpful.

Some local authority areas have witnessed trends towards consolidation in the private sector and expressed concerns that, in time, this may lead to the market being dominated by a small number of larger suppliers to the potential detriment of local authorities. Where there are only a limited number of local suppliers, the local authority's bargaining position is potentially weakened when negotiating contracts for the purchase of services. Small numbers potentially facilitate 'private' agreements between suppliers on local pricing structures, and the absence of local competition then allows prices to be maintained at an artificially high level for local authorities (and also for individuals who may purchase services for themselves).

There were suggestions from some local authorities that private providers are actively helping their clients to apply for free personal care in order to ensure that the client gets the maximum local authority funded provision. Although they felt that such actions had helped to increase the numbers receiving free personal care, and to put pressure on local authority resources, interviewees generally saw this as a positive benefit for service users. A number of local authorities have also seen changes in the private contractual and funding arrangements of clients who previously, because of their financial circumstances, had not been eligible for free local authority provided services and had sourced care privately. They noted that, in a number of cases, the service user had now been assessed as requiring personal care and some private providers are now engaged through the local authority to provide free personal care while still contracting directly with clients to deliver other domiciliary care services. Although it had financial implications for the authorities concerned, interviewees saw this change as positive. Individuals in these cases may not have been known to the local authority prior to their assessment for free personal care. Care needs frequently become more complex with increasing age, and it was helpful for local authority planning to have established a relationship with a service user who might require more intensive support or care home placement at a later date.

Accessing free personal care

- Interviewees found the use of the term 'waiting lists' unhelpful and stressed that rapid assessments were neither feasible nor appropriate in cases involving people with complex care needs.

- Some authorities operated, or had previously operated, 'priority registers' and/or standard delays following assessments in making free personal care payments to self-funding care home residents. These were deemed necessary for financial reasons.

Considerable media attention has been focused on 'waiting lists' for assessments, home care services and payments to care home residents since the introduction of free personal care. Interviewees were disturbed by the popular media's use of the term 'waiting lists', which they considered to be particularly emotive, without a fuller explanation of its meaning. Some authorities indicated considerably increased volumes of complaints following the publication of 'league tables' of waiting list information. Interviewees' frustration at media headlines was typified by one who said:

> When we get put on a list of saying we are keeping people waiting … it's just the practicalities of doing it. That's what it's about. It's not about, you know, some major policy.

One suggested that they 'would not use "waiting time" as a description of any part of the assessment process'. Most were at pains to stress that assessments begin as soon as practicable given the resources available to them, but that the assessment process is neither quick nor easy where clients have complex care needs:

> The assessment process itself may take four or five weeks. We're trying to cut that down but it's not easy to cut that down because you're making major changes to someone's life and the more and more we try and turn that into an Olympic sport the more we'll miss the person at the centre of it.

That said, some local authorities did report operating 'priority registers' and/or standard delays for making free personal care payments to self-funding care home residents following assessment, or had done so in the past. Local authorities cited financial constraints as the reason for instituting priority registers. Interviewees suggested that some older people and their families chose to fully fund the costs of their care home place until personal and nursing care payments were made rather than delaying entry into a care home until payments were available. Where care home residence was to be fully funded by the local authority it was not possible to

operate similar delays once placements were made. This is because these older people who are fully funded by the local authority do not have sufficient financial resources to contribute to charges in any interim ‘delay’ period, and would not be accepted into a care home unless the local authority had agreed to pay their full charges from the start. This meant that local authorities with larger numbers of older people from areas of relative deprivation had less control over this element of their spending under the free personal care policy.

Interviewees were not insensitive to the problems that delays in eligibility caused for some applicants for free personal care payments and regretted that they had felt obliged to operate such systems. They noted that the imposition of payment delay mechanisms for free personal care payments also has repercussions for front-line staff. Such staff were forced to manage the expectations and disappointment of carers and service users who might not appreciate either the existence of ‘priority registers’ and/or standard delays or the local authority’s need to operate them.

Some authorities had ceased to operate priority registers following legal advice or lessened payment delays following a commitment to additional funding from their elected members. They suggested that doing so had ‘accelerated cost pressures’ and that it had meant drawing on funds from elsewhere in local authorities’ budgets. One interviewee commented on the need to repeatedly make additional funds available to keep up with demand, saying ‘we wonder why they call them one-offs because we’ve had those one-off spends for the last three years’. Another pointed to the difficulty in reconciling public and elected members’ expectations with local authority budgetary constraints, commenting:

> It will not save me you know, if I’m five million overspent, to say ‘But nobody waited’.

Complaints

- The volume and substance of complaints varies, and is reported to be influenced by media coverage.

Complaint volumes in relation to free personal care had varied between authorities in terms of both numbers and substance of complaints. There is public awareness of continuing debates around some aspects of the policy – for example, assistance with food preparation (discussed in detail later in this report) – and some authorities had experienced higher complaint volumes about those issues. In others, complaints usually centred on disputes about the magnitude of the charge levied by the local

authority for home care services. Such complaints were seen by interviewees as often prompted by confusion over the rules for calculating chargeable income or failure to appreciate the distinction for charging purposes between personal care tasks and non-personal domiciliary care tasks such as house cleaning. Authorities that had instituted priority registers found that their complaint loads had increased. Other interviewees noticed that people were demanding larger care packages in terms of numbers of hours of services even where they had not been assessed as needing them. The Care Commission interviewee suggested that the Commission experiences surges in complaints when care-related issues receive local or national media coverage, many of which are outside of the Commission's remit and are referred back to the relevant local authority.

Direct Payments

- There may be a small increase in requests for Direct Payments, especially from former self-funders receiving care at home.

Some authorities reported a recent increase (albeit small) in requests for Direct Payments.[11] These were said to be coming from people who had previously paid privately for care and saw free personal care as an opportunity to get some care without paying, therefore cutting their own costs while retaining their choice of services. Personal assistants were said to be a popular use of Direct Payments. One authority noted that an increase in Direct Payments might threaten the viability of its own in-house provision. Its concern was that the future widespread take-up of Direct Payments might affect its ability to achieve the same economies of scale as at present. However, it believed that delivering high-quality services would encourage service users to accept services from the authority rather than making alternative private arrangements.

In one case, since the possibility of Direct Payments supporting the continuation of private arrangements existed, a respondent felt that some of the stigma of seeking help from the local authority had been removed. This was, of course, initially because of the availability of Direct Payments, but free personal care made applications for them more worthwhile for people on high incomes. Other respondents noted that the outcome of some applications for assessment and support was that people accepted the free elements of their packages, but declined the elements for which they would be charged, 'making do' with informal care or other private arrangements. It was pointed out that this was not a new phenomenon created by the free personal care, but one with which the authorities were previously very familiar.

Data issues

- Data are being generated about service delivery under the free personal care policy but local authorities face continuing difficulties with IT systems that cannot produce information in required formats.

One key consequence of the free personal care policy was improvements in the data about personal care and the quantity of services being provided. Before the implementation of the policy, such information had not been available and there had been no baseline against which to assess the impact of free personal care. After four years' operation of the policy, respondents felt that they had more robust information, especially about increased demand and the rising cost of delivering the services. This was generally welcomed and seen as a resource in negotiations with the Scottish Executive.

However, while better data were welcomed, many authorities described difficulties with their IT systems, which could not necessarily produce information in the forms requested by the Scottish Executive, thus necessitating extra work on statistics at local level. There were particular problems attached to sharing information across health and social care services. While these were not caused by free personal care, they did contribute to some difficulties of monitoring resource use.

Indirect impacts

Exacerbating pre-existing problems

- The free personal care policy was perceived as amplifying the effect of certain factors contributing to variation in service users' experiences of local authority care services prior to its introduction. Such factors include prior charging regimes, local demography and geography, and local workforce supply.

In general, the interviews demonstrate the continuing importance of variation between local authorities according to factors such as charging regimes prior to free personal care, local demography and local conditions such as workforce supply, rurality,[12] housing patterns and so on. These have affected and continue to affect local authorities' abilities to deliver care services to people with care needs. The free personal care policy did not create these variations, but has in some cases amplified their effects.

For example, differences in local authority charging regimes prior to free personal care affected both authorities and service users. The introduction of free personal care reduced incomes from charging for care services across all authorities. Some local authorities had previously provided users with care services at greatly subsidised rates or without charge. They had formerly received less income from charging for care services and therefore needed to compensate less for the reduction. However, service users in those local authorities perceived less benefit from the introduction of free personal care because they had already been receiving care services at lower costs. Authorities that had previously had less generous policies and thus more income from providing care experienced greater problems adjusting to the loss of income. These authorities also tended to see a more marked surge in demand for care services with the introduction of free personal care.

In addition to variation in the timing and nature of increases in demand for care services, there is also great variation in local authority spending per client on free personal care at home. This is discussed in detail in the section on 'Heterogeneous local authorities?' in Chapter 3. There is independent evidence to suggest that it is possible to provide high-quality services while maintaining low relative expenditure per client.[13] The wide variation in expenditure per client is again explained to a large extent by divergent historic social care policies across authorities.

While pre-existing problems faced by local authorities have in many instances been exacerbated by increased demand following the introduction of free personal care, these problems have also been affected by increasing difficulties in recruiting care workers, especially those delivering home care services. The reasons for recruitment and retention difficulties appear to vary across different local authorities. Some interviewees suggested that, in their authority, there was a shrinking pool of available labour either because of demographic changes caused by ageing populations and/or the migration of younger people out of more rural areas or areas with high housing costs. Others pointed out reductions in the numbers of women taking up care work positions because more are engaged in other full-time employment than in the past. The availability in some areas of other forms of employment – for example, call centres, which are perceived as offering more attractive pay and conditions – was seen by some as a barrier to recruitment. One interviewee also cited a disinclination on the part of current and prospective 'home helps' to take on the delivery of personal care tasks.

In addition to recruiting sufficient numbers, interviewees identified difficulties attracting the right calibre of staff. Registration requirements were seen as having introduced additional recruitment problems and respondents noted that expansion in the private and voluntary care sectors has led to increased competition within local

labour pools. Recruitment problems, however caused, were seen as a key factor in the difficulties experienced by many authorities in meeting demand for and delivering care services. These difficulties were particularly acute in those authorities that had experienced increasing demand for care services at least partly as a result of the introduction of the free personal care policy.

Changing availability of private sector provision

- Local authorities noted increases in the provision of private sector home care and the commissioning of larger private care homes. These increase choice for clients, but also raise concerns about the expenditure of free personal care monies. The Care Commission is currently investigating pricing structures in care homes.

In addition to generally sourcing more home care provided by the local authority from the private sector, most authorities had seen increasing private sector provision of home care locally. Generally, this was explained as having resulted from increased demand for services over recent years, with the increase made greater because of free personal care. In several cases there was anecdotal evidence that private agencies were referring people to the local authority for assessments to take advantage of free personal care (in some cases through Direct Payments, as noted above). One respondent pointed out that, prior to free personal care, the council had little knowledge of private care purchased independently by older people and suggested that the recent trend might simply represent the emergence of previously existing private arrangements into the public arena.

Respondents found it difficult to say whether raised demand for home care was a consequence of free personal care or whether this was primarily because of demographic change. However, several respondents felt that publicity about free personal care could have raised expectations, and encouraged more people to seek help from the local authority. The Care Commission expressed hopes that the introduction of free personal care had indeed played a part in raising public expectations. Higher expectations were seen as a key driver for higher service quality and wider choice.

Many local authorities have witnessed changes in care home availability since the introduction of free personal care. Trends have been noted in terms of shifts from smaller to larger care homes, a general drift from larger numbers of smaller private providers to smaller numbers of national providers and, in many instances, contractions in local authority owned provision. The changes are seen as in part

related to new requirements under National Care Standards and not the result of free personal care, but they do affect authorities' abilities to offer care home placements and in some instances local authorities attribute 'waiting lists' to a scarcity of places. There is substantial variation in the extent to which different local authorities are affected by changes in local care home markets. Some authorities are now benefiting from longer-term strategies that were adopted prior to the introduction of free personal care in relation to ensuring sufficient care home capacity.

The Care Commission also notes trends towards smaller numbers of care home providers and far larger care homes. The Commission has concerns over the extent to which payments under the free personal care policy to residents of care homes assessed as having personal care and nursing needs have improved services for those people. It is currently investigating concerns that the new payments were simply absorbed into care home charging structures with no resultant improvement in the quality of care.

Changes in informal caring

- Interviewees saw evidence of changes in informal caring, with the participation of service users and informal carers in shaping and defining their care packages perceived as more visible than prior to the introduction of free personal care.

All the interviewees discussed informal care. As we note elsewhere in this report,[14] free personal care does not seem to have produced a decline in informal care. However, while there have not been quantitative changes, there is some evidence that there have been qualitative changes. Respondents offered anecdotal evidence that informal carers are switching to performing non-personal care tasks and therefore maximising the overall amount of care a person receives. In that sense, free personal care supports informal carers in the ways that were anticipated in research carried out around the introduction of the policy.[15]

Authorities reported that they could not be sure of the extent of substitution because they did not have baseline data about what tasks informal carers performed. In general, they knew that numbers of clients had increased, but not whether informal care had stopped or been replaced. In some authorities, there was evidence of an apparent withdrawal of informal care, with informal care frequently being reinstituted once clients realised that free personal care did not cover as much as they might have thought. All this supports our previous finding of the active participation of clients in the care system and their making strategic choices about care packages. The participation of service users and carers in shaping and defining the outcomes

of care packages is not new, but is perhaps more visible since the introduction of free personal care.

Problems and perceived problems with the free personal care policy

- Variations in the political commitment of different authorities to the funding of free personal care were perceived as contributing to continued variation in service user experiences across authorities.

- Interviewees perceived a lack of detailed understanding of the policy by some members of key stakeholder groups including the general public, health care professionals and elected representatives. This led to difficulties in ensuring informed local policymaking around free personal care and was also perceived as leading to higher numbers of complaints.

- The continued payment of Attendance Allowance to those receiving personal care at home was regarded as anomalous by some interviewees.

- Local authorities felt that guidance from the Scottish Executive was sometimes unclear, especially in relation to tasks associated with food preparation.

Variation in local policies

Several interviewees noted that effective delivery of free personal care required political commitment on the part of the local authority. Local authority finances are finite and decisions on spending priorities have to be made. Variations in the local political will to prioritise spending on free personal care played a part in creating differences in how the policy was experienced by service users in different local authority areas. For example, as previously noted, decisions such as whether and how to operate waiting lists varied between authorities. Differences in service user experiences between authorities were highlighted in the Scottish Parliament Health Committee Inquiry Report, which included data on delays in assessments for, and the provision of, services under free personal care.[16] Variations are additionally reflected, for example, in the figures for care home and care at home clients, annual spending per client on care at home and so on. The section entitled 'Heterogeneous local authorities?' in Chapter 3 reflects on the heterogeneity of local authorities across a range of relevant variables.

Lack of detailed understanding of the policy

Local authorities felt that there was widespread public awareness of the introduction of a policy of free personal care across Scotland thanks to extensive media coverage of the Scottish Parliament's decision to adopt such a policy. However, interviewees felt that public understanding of what the policy actually entailed and how it fitted into a framework of needs assessment was and remains incomplete in some local authority areas. This is despite the Scottish Executive's initial information leaflet and the considerable efforts of many local authorities to 'educate' their clients early on about what tasks might be covered and how the system would work.

The distinction between personal care and other domiciliary care is still not clear to some and the meaning of concepts such as 'hotel costs' in relation to care home placements is not obvious. As the previous research noted,[17] service users frequently have a 'holistic' view of their own care needs and do not distinguish between care tasks in the ways in which policy initiatives such as free personal care and Supporting People do, particularly when all the different care services that they receive are delivered by the same person. Some authorities noted that front-line service workers also find distinctions between personal care and domiciliary care artificial and in some respects blurred.

Common and persistent public misconceptions noted by local authorities include: that all community care will be free; that care will be provided without the need for assessment; that there is no longer any requirement for means testing in connection with care services; and that it will never be necessary to sell one's home to contribute towards the costs of care home placement. In certain authorities, public lack of awareness of the financial constraints to support under the policy has been a particular problem. The Care Commission's complaint load also indicates continued confusion as to what service users are entitled to expect under the free personal care policy.

It is not clear whether public misapprehensions can be attributed to a lack of information concerning the policy. Some authorities were critical of the relatively small amount of general publicity material produced by the Scottish Executive and believed that, more than four years after the implementation of free personal care, more publicity material from the Scottish Executive would be helpful. Others believed these persistent misconceptions were the result of the public not normally engaging with either the care system or the policy until specifically prompted to do so. These authorities felt that, until a precipitating event occured, most people's understanding of the policy tended to be informed by media coverage. Interviewees saw such coverage as frequently lacking in detail, on some issues unhelpful and in some instances misleading.

Authorities also expressed concerns about the consequences of limited understanding of the policy in specific groups such as elected representatives and health professionals. Interviewees felt that the complexities of aspects of the free personal care policy caused problems in trying to explain why a local authority might need to adopt certain policies and/or practices. Local authorities felt that the situation had not been helped by what was seen as a lack of leadership from the Scottish Executive over some issues. They cited as one such issue the question of assistance with food preparation and whether that was a personal care task to be delivered free or a chargeable non-personal care task. Interviewees felt that some council members found the age-related limitation on policy beneficiaries across groups with similar care needs difficult to reconcile. In addition, it was suggested that limited understanding by care professionals led on occasion to clients and their families not making fully informed choices between care at home and care home placements.

Increases in the number of complaints had accompanied raised expectations, publicity about free personal care and misinformation about the policy. In some instances, court cases were pending, especially around the issues of charging for meal preparation and for provision of meals (see below). The Care Commission received a variety of complaints related to free personal care, but these tended to relate to points around charging or the extent of care packages, rather than the impact of free personal care as such. It was felt that the complaints received by the Commission highlighted both service users' misunderstandings of what they could legitimately expect under the policy and their misapprehension of the Commission's ability to look into complaints on issues not related to service quality.

Benefits-related anomalies

Anomalies in relation to benefits were also seen as illogical. For example, some interviewees found it difficult to understand the justification for the continued payment of Attendance Allowance to people receiving home care services. Attendance Allowance is a benefit to help those eligible to receive it to pay for certain personal care needs, but interviewees believed that those needs are being met by services provided without charge by the local authority under the free personal care policy, suggesting that perhaps Attendance Allowance is not therefore needed. Statistics indicate that in fact large numbers of people receiving Attendance Allowance do not receive free personal care from local authorities. We consider this further in Chapter 3.

Perceptions of unclear advice

In some cases, there were strong comments about the Scottish Executive's advice, which was felt to be unclear. One respondent felt that politicians were ignorant about the real implications of free personal care and supported unjustified complaints. National politicians were said to have 'abrogated responsibility' for the policy and left it to local authorities to deal with the problems.

All the local authorities interviewed commented on the continuing issues around meals preparation, which, at the time of the research, appeared likely to give rise to a number of court cases. The issues centre on whether or not charges can be made for 'food preparation' and 'assistance with the preparation of food'. The statutory definition of 'personal care' on which the free personal care policy draws is contained in the Regulation of Care (Scotland) Act (2001), which states in Section 2(28):

In this Act, unless the context otherwise requires:

> 'personal care' means care which relates to the day to day physical tasks and needs of the person cared for (as for example, but without prejudice to that generality, to eating and washing) and to mental processes related to those tasks and needs (as for example, but without prejudice to that generality, to remembering to eat and wash).

In 2002, the Scottish Executive provided initial guidance to local authorities on the implementation of the policy to be used in the implementation process, which offered 'further explanation of the components of personal care'.[18] The guidance suggested that personal care should be understood as encompassing, among other things, 'assistance with eating, managing special diet and preparing specialist meals such as pureed food'.

In 2003, the Scottish Executive Health Department consolidated guidance on free personal care[19] stated that:

> … food preparation and provision of meals are not included. However assistance with eating, assistance to manage special diets and the assistance with the preparation of specialist meals (e.g. pureed foods) is included.

However, in a letter issued in September 2004 to local authorities,[20] the Executive provided clarification, suggesting that 'assistance with the preparation of food should not be charged for'.

The recent Scottish Parliamentary Health Committee Care Inquiry found that the Scottish Executive had failed to enforce clear guidance on key aspects of eligibility, such as the preparation of meals. The Inquiry Report contained a recommendation that:

> The Scottish Executive should enforce the guidance on those aspects of eligibility which local authorities claim remain ambiguous. It should ensure that services such as assistance with meal preparation, where they are part of assessed need, are eligible for free personal care.[21]

In its response the Scottish Executive indicated that steps had already been taken to address this issue, with a further letter having been issued to all local authorities on 25 May 2006 offering guiding principles that local authorities should apply when considering whether or not to charge for services.[22] The letter distinguishes between the terms 'assisting with the preparation of food' and 'food preparation'. It points out that the former is of a kind mentioned in Schedule 1 to the Community Care and Health (Scotland) Act 2002, whereas the latter is not. Under Section 1(c) of the Act, local authorities are not to charge for social care provided or secured by them if that social care is care of a kind mentioned in Schedule 1 to the Act. The letter indicates that 'meal provision' is also not included in Schedule 1. The final paragraph of the advice acknowledges the difficulties faced by local authorities in deciding at what point non-chargeable 'assistance with food preparation' becomes potentially chargeable 'food preparation' when it suggests that 'interpretation of the law is ultimately a matter for the courts' and that:

> The approach to delivery of services remains a matter for local authorities, having regard to local circumstances and the assessed needs of the individual.

Some participants stated that they would welcome a court decision. Legal advice had been taken in several cases, and those interviewed included authorities that had ceased charging or paid back money on legal advice. Authorities that felt this issue was less of a problem had set out what they saw as clear rules or had divided responsibility for delivery of meals services clearly between different budgets. However, they still felt there were difficulties. One interviewee referred to 'ambiguity and misdirection from the Scottish Executive' in this context.

Difficulties defining task-related boundaries

In these interviews, respondents were less likely to speak of confusion with overlaps between Supporting People tasks and services and those provided in relation to free

personal care than when interviews had taken place in November 2004 for the earlier research.[23] They saw continuing difficulties in this area as more about defining the task-related boundaries between non-personal care at home and housing support services. Under the Housing (Scotland) Act 2001 (Housing Support Services) Regulations 2002, services that can be provided under the Supporting People programme include 'Assisting with shopping and errands where this does not overlap with similar services provided as personal care or personal support'. Interviewees did, however, draw contrasts between Supporting People budgets and free personal care budgets. Supporting People funding is 'ring-fenced'. That is to say that local authorities cannot spend their Supporting People Grants on providing services other than for Supporting People. Indicative amounts for spending on free personal care are included in the GAE, but there is no ring-fencing of the free personal care budget. Local authorities can plan in advance how to use Supporting People funds. It is less straightforward to plan expenditure and control the free personal care budget because authorities cannot control the numbers of eligible service users. In addition, while the local authority contribution under free personal care is fixed for care home residents, there are, in theory, no limits to the potential costs of care packages where free personal care is delivered at home.

Perceived limitations to the policy

- Interviewees expressed concerns relating to the differential impact of the free personal care policy on different community care service user groups.

Interviewees noted the differential impact of the policy on particular client groups and identified three groups of community care service users as exemplifying potential injustices. The first was older people with higher incomes and greater financial resources. This group, and those who stand to inherit their estates, were seen to be the major policy beneficiaries. The second group was people under the age of 65 with assessed personal care needs. These people did not benefit from the free personal care policy, but interviewees were concerned to highlight what they saw as the inequity of provision to this class of service user. The third, more loosely defined group consisted of the users of community care services, both over and under 65, not related to free personal care. These service users were seen by interviewees as having been indirectly disadvantaged by the impact of providing services under the free personal care policy on the development and availability of other community care services.

There was a widespread perception among interviewees that, within the overall numbers of those eligible for help under the free personal care policy, financial

benefit had been derived by those in higher income groups. This was often seen by the interviewees as having been at the expense of those on lower incomes. Those we spoke to suggested that, under previous charging regimes, service users on lower incomes received care from the local authority either free or at greatly reduced rates and thus perceived little or no benefit from the introduction of free personal care. Interviewees saw the introduction of free personal care as having encouraged those on higher incomes who might in the past never have contacted the local authority to request assessments for local authority provided care services. There was a tendency among some interviewees to link the emergence of this group with subsequent free personal care budgetary pressures. Interviewees also identified the loss of income from charges paid by relatively affluent older people for personal care services provided by local authorities as having an impact on community care resources. Such pressures were seen as having significantly influenced the imposition or tightening of service eligibility criteria and having contributed significantly to the subsequent restriction on the numbers of people with lower-level care needs able to access care services.

Issues around the 'appropriate' distribution of local authority resources are emotive and to an extent influenced by interviewees' political beliefs. They also arouse strong feelings in members of the general public. The general principle that all older people assessed as having personal care needs should receive personal care at home provided or arranged by the local authority free of charge, *irrespective of their financial position*, is central to the free personal care policy. However, several authorities indicated that, when this aspect of the universality of the policy was explained at public meetings, it met with disbelief and anger from some quarters – a further indication that the detail of the policy is not publicly well understood. Interviewees said that members of the public frequently felt that it was inappropriate that apparently wealthy older members of the community with assessed care needs should still be eligible for free personal care at home or for personal and nursing care payments if they were resident in care homes.

While most interviewees identified an emerging group of affluent older people with personal care needs and relatively substantial financial resources as the major policy beneficiaries, no empirical evidence was offered by them to substantiate the causal links that were suggested between the emergence of this group and the increasing costs of the free personal care policy. In fact, evidence about the incomes of older people[24] tends to suggest that the proportion of service users with higher incomes prompted to seek local authority assistance following the introduction of free personal care ought to be relatively small.

The most recent analysis of data on British pensioners' incomes[25] indicates that the distribution of pensioners' incomes is skewed towards lower incomes. Older single pensioners, the group most likely to be eligible for free personal care, have lower average incomes than others. In 2004/05 a single pensioner aged over 75 had a mean net income after housing costs of £165 per week (median £137), compared with a mean of £174 per week (median £140) for a single pensioner aged under 75 and £187 (median £145) for a recently retired single pensioner. In the same year, the average income for the general population was £431 per week. Thus, older people's incomes in general are low, relative to average incomes.

In addition the sources of income vary between pensioner groups. This is relevant because many types of benefit income are partly or wholly disregarded under local authority charging policies. Older people for whom benefits constitute a large proportion of income are likely to have paid reduced or minimal charges for care prior to the introduction of free personal care. For single pensioners aged over 75, on average, 65 per cent of gross income came from benefits, with a further 22 per cent derived from occupational pensions and only 13 per cent from other sources. This compares to 47 per cent from benefit income, 22 per cent from occupational pensions and 31 per cent from other sources for recently retired single pensioners. Such data might tend to suggest that the proportion of service users with higher incomes prompted to seek local authority assistance following the introduction of free personal care ought to be relatively small, and that interviewees' focus on this group in particular is misdirected.

Interviewees tended to see those people under the age of 65 with care needs who do not have the same access to free care services as a second group to have been differentially affected by the free personal care policy. While they had not been disadvantaged as such, it was widely regarded as inequitable and discriminatory that people with identical care needs are asked to pay substantially different amounts for the same care packages based on age. That said, one interviewee felt that age discrimination operated against older people in terms of local authority preparedness to consider very intensive high-cost care at home packages rather than care home placements with lower associated costs for the authority. They saw the latter as being considered more readily for older people than for younger people with similar care needs.

The third, more loosely defined group identified by interviewees as having been affected by the implementation of free personal care consisted of the users of community care services not related to free personal care. These service users were perceived by interviewees to have been indirectly disadvantaged by the impact of providing services under the free personal care policy on the development and

availability of other community care services. Interviewees saw other services, especially lower-level support services, as potentially suffering because of the need to service local authorities' financial commitments under free personal care from general community care budgets in addition to monies allocated for care home payments and the care of older people under the GAE. These observations could be linked with a more widely reported tendency across the UK for eligibility criteria to be tightened, thus concentrating resources on those with higher levels of need, including personal care needs.[26]

3 The bigger picture: statistical analysis

Introduction

This chapter looks at how the costs of personal care have evolved since the introduction of free personal care (FPC) by the Scottish Parliament in July 2002. It identifies the sources of increased demand for personal care, using additional data that were not available when we wrote our first report.[1] Echoing our original findings, one of the findings of this report is that there are great variations between local authorities in the costs of delivering the policy. As a result, there is wide variation across authorities in the apparent difficulty of funding the policy. These variations are not reflected in the funding allocated by the Scottish Executive to meet the costs of personal care in different local authorities. Hence this chapter also examines the mechanisms by which funds are allocated by the Scottish Executive to local authorities to pay for personal care.

Changes in demand for personal care since 2002

- There has been a 62 per cent increase in provision of free personal care at home and a 29 per cent increase in care home provision during the first three years of the policy.

- A number of factors do not appear to have caused increases in demand.
  - The evidence available does not support unforeseen demographic change as a source of unexpected increase in the demand for personal care since 2002.
  - Unexpected increases in actual disability among older Scots are unlikely to explain the increase in the demand for personal care since 2002.
  - There is no strong evidence that a decline in the quantity of informal caring has been a major source of the increased demand for personal care observed in Scotland between 2002 and 2005.

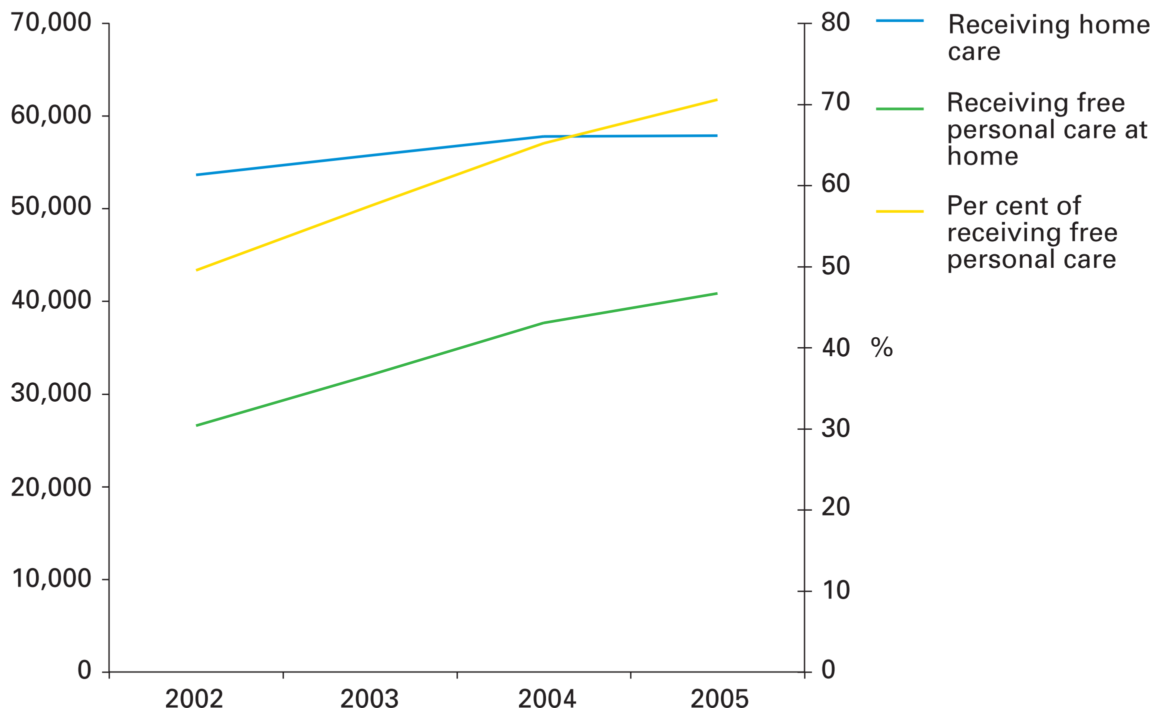
- There is some evidence that the following factors may have increased demand.
  - Unmet need on the part of people not previously receiving local authority services, who either paid for their services privately or used Attendance Allowance only.
  - While informal carers have not withdrawn from care, there is some evidence that their behaviour is changing and they are performing different, non-personal forms of care.

- When viewed purely from a local authority perspective, the cost of care for older people is rising. However, when viewed from a more global perspective that includes health care costs, the cost of care for older people in Scotland may be falling, as hospital care decreases and more people receive care at home.

Care at home

There was a 10 per cent increase in the overall number of local authority home care clients between 2002 and 2005. Within this group, the number receiving personal care increased by 62 per cent, to 39,000 (Figure 1). As a result, the proportion of home care clients receiving personal care increased from 50 per cent to 71 per cent over the period (Figure 1, right-hand axis). The number of personal care hours supplied by local authorities increased by 67 per cent between 2002 and 2005. This is a larger increase than the number of clients; hence the average weekly hours of personal care provided in clients' homes has also increased, though only slightly. However, this masks some change in the distribution of hours. Some clients are being given fewer hours, while others are receiving more care hours per week. Between 2002 and 2005, the proportion of clients receiving ten or more hours of care per week increased from 13.3 per cent of clients to 17.1 per cent.

Figure 1 Number of clients receiving free personal care at home



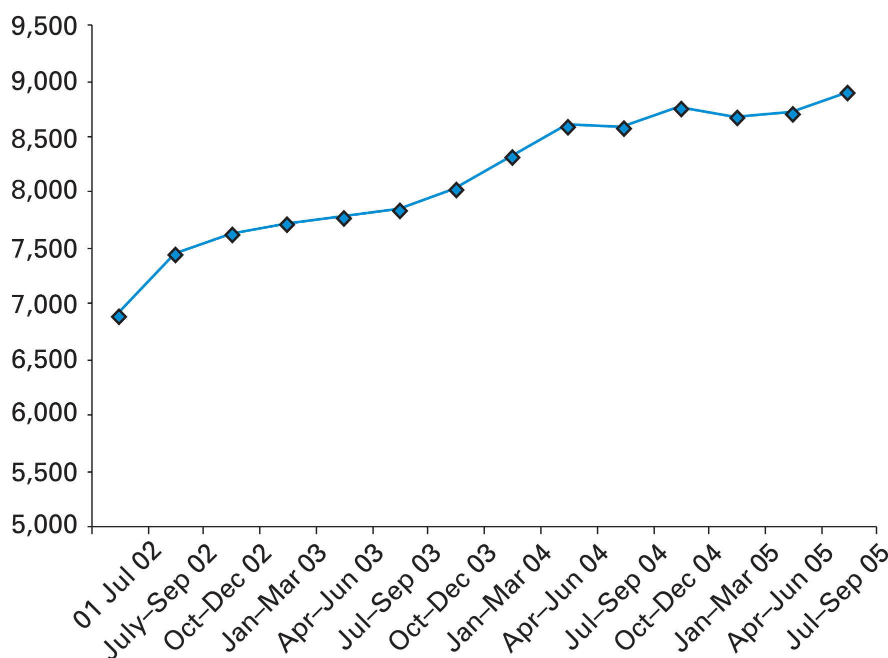
Source: Scottish Executive Community Care Statistics.

Thus, there has been a substantial increase in the number of local authority clients receiving FPC at home since 2002. Their number has grown much more rapidly than the overall number of social care clients. There has been a slight increase in average hours per client, but this conceals a significant increase in the number of clients receiving extensive weekly home care packages.

Care homes

The number of care home clients receiving free personal care increased by 2,000 between 2002 and 2005 (Figure 2). This implies extra annual spending of £15.1 million on personal care (£145 per client week). Some of these additional clients also receive £65 per week for nursing care. As we mentioned in our previous report, both the payments for personal and nursing care in Scottish care homes have not changed since July 2002. In contrast, the banded payments for nursing care in England have increased steadily since 2002 and now stand at £40 for the lowest band, £83 for the intermediate band and £133 for the highest band.

Figure 2 Number of clients receiving free personal care in care homes



Source: Scottish Executive Community Care Statistics.

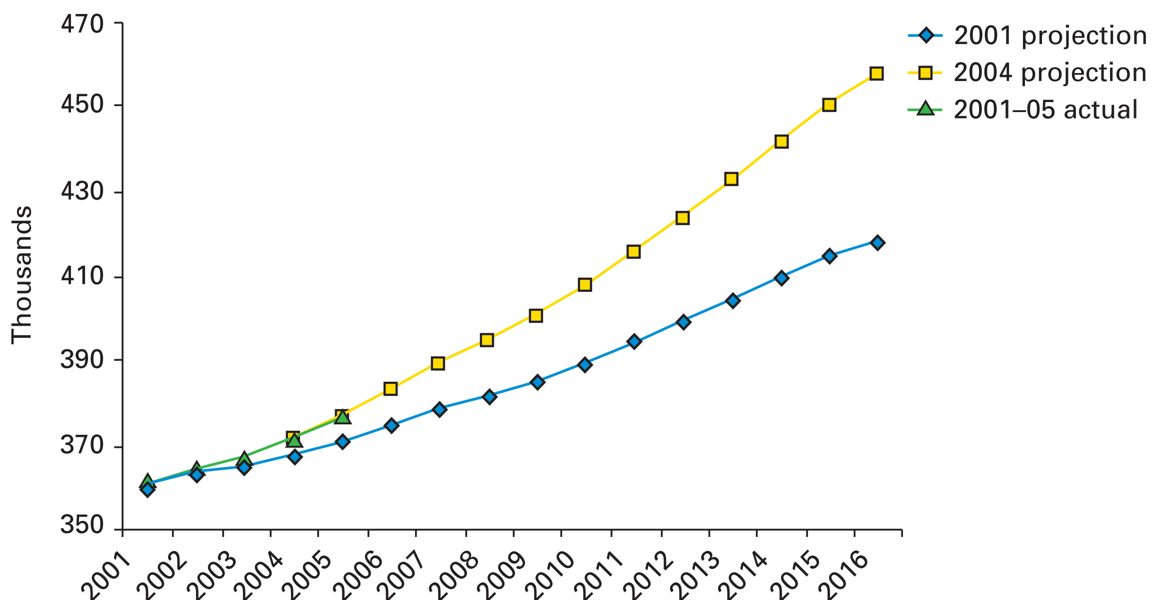
Thus, between July 2002, when the policy was introduced, and September 2005, there has been an increase of 17,000 clients receiving free personal care. Of these, 15,000 receive free personal care at home and 2,000 in care homes. There has been a 62 per cent increase in provision of free personal care at home and a 29 per cent increase in care home provision during the first three years of the policy.

These are substantial increases; it is clearly important to identify their underlying causes. Possible explanations, which we now consider, are: increases in the size of Scotland's older population; increases in rates of disability among older people; reductions in informal caring; and changes in the pattern of care provision from health to social care.

Demographic change

Figure 3 shows information on the size of the Scottish population aged 75 and over between 2001 and 2016. It shows actual data from 2001 to 2005, based on registrations of vital events (births and deaths), and two sets of projections to 2016, produced in 2001 and 2004. The 2001 projections were available before the free personal care policy was introduced. The 2004-based projections make allowance for new information that has become available since 2001, including the population estimates for 2004.

Figure 3 Scottish population aged 75 and over, 2001 to 2016, actual and projected



Source: Government Actuary's Department and General Register Office Scotland.

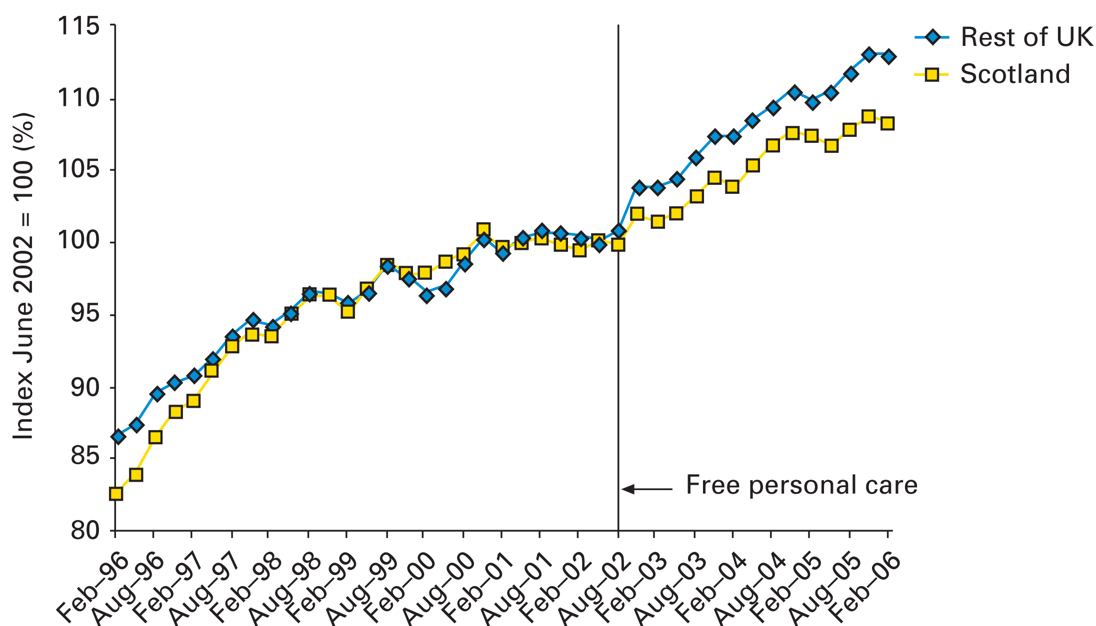
It is clear that the 2001 projection underestimated the actual rise in the 75 and over population between 2001 and 2005. The 2004-based projections reflect this underestimate and suggest that, by 2016, the Scottish population aged 75 and over will be 85,000 (16.7 per cent) more than that expected in 2001.

However, Figure 3 also shows that the underestimate of the over-75 population from the 2001-based projections and the 2005 outcome is relatively small. It amounts to 62,000 people. Only a small proportion of these will require personal care. Hence, we would eliminate unforeseen demographic change as a source of unexpected increase in the demand for personal care since 2002.

Disability

Could the increase in the demand for free personal care be explained by a sudden increase in disability among older Scots since 2002? One answer to this question can be found by looking at how the number of claims for Attendance Allowance (AA) has varied in Scotland and the rest of the UK in recent years (see Figure 4). AA is a tax-free benefit for people aged 65 or over who need help with personal care because they are physically or mentally disabled. It is paid by the Department for Work and Pensions (DWP) and does not come out of the Scottish Executive budget. It is normally assessed by doctors in conjunction with DWP assessors.

Figure 4 Index numbers of Attendance Allowance claimants: Scotland and rest of UK, 1996–2006 (June 2002 = 100)



Source: Department for Work and Pensions.

It is clear from Figure 4 that there was an increase of around 8 per cent in the number of claimants in Scotland between 2002 and 2006. This increase was a continuation of an upward trend that had begun well before free personal care was introduced. The increase in AA claimants in Scotland has been less rapid than in the UK as a whole. If the number of claimants had grown as fast as in the rest of the UK, there would have been an additional 61,000 claimants in Scotland by early 2006. But the number of claimants is growing relatively more slowly in Scotland because self-funding residents in care homes receiving FPC are no longer eligible for AA. There were 89,000 self-funding clients in care homes at the end of 2005, suggesting an 'excess' growth of AA claimants in Scotland relative to the UK as a whole of 28,000, or 2 per cent of the current stock, assuming all were eligible for AA. Therefore the introduction of FPC has resulted in only a small increase in AA claims relative to the rest of the UK. We consider the financial implications of the subsequent removal of AA from care home clients.

There are now around 140,000 individuals receiving AA in Scotland. But, as at September 2005, there were only 57,000 home care clients and 9,000 self-funding care home clients receiving free personal care in Scotland. This suggests that there are around 74,000 individuals who have been assessed by a doctor as requiring help with personal care who are not receiving free personal care from local authorities. In practice, there is no reason to expect all of these individuals to meet the local authority assessment criteria for free personal care, but it may well be the case that the new policy in Scotland has caused a larger proportion of this group to seek assessment than has previously been the case. We have indicated our concern with this somewhat anomalous situation in our previous report (Bell and Bowes, 2006), pointing out that the reasons for the discrepancy between AA and social care client numbers are not well understood.

Given that AA claims have grown only slightly more rapidly in Scotland than in the rest of the UK, it seems unlikely that an unexpected increase in actual disability among older Scots explains the increase in the demand for personal care since 2002. However, the difference in the growth rates of AA claimants and of home care clients receiving personal care may imply that there has been unmet need for the type of personal care provided by social services. It follows that, once this unmet need has been met, one would expect the growth in demand for personal care to more closely mirror the increase in AA.

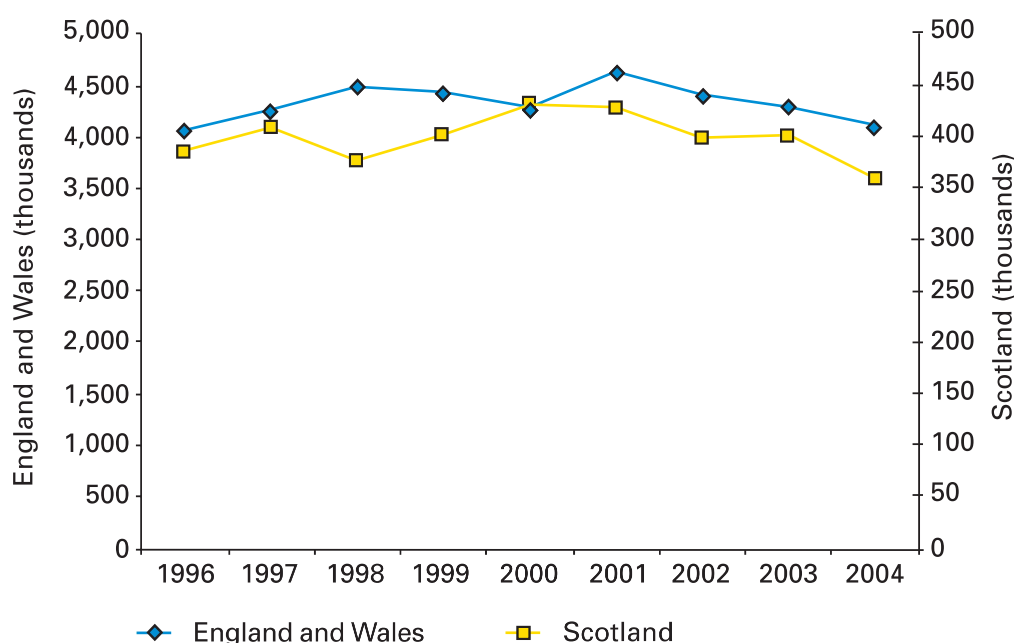
Informal caring

Has there been a reduction in informal caring that might explain the increase in demand for formal care provision?

Our earlier research (Bell and Bowes, 2006) indicated that there had been no significant reduction in informal caring at least in the first two years following the introduction of free personal care. Since our first report, a further year of data has become available from the Family Resources Survey.

Figure 5 shows the number of carers in England and Wales (left-hand axis) and Scotland (right-hand axis) up to 2004. There has been a slight decline in informal caring throughout Great Britain in recent years, but the fall in Scotland is not significantly greater than the decline in the rest of Great Britain. Hence, it is difficult to attribute this decline to the effects of the free personal care policy.

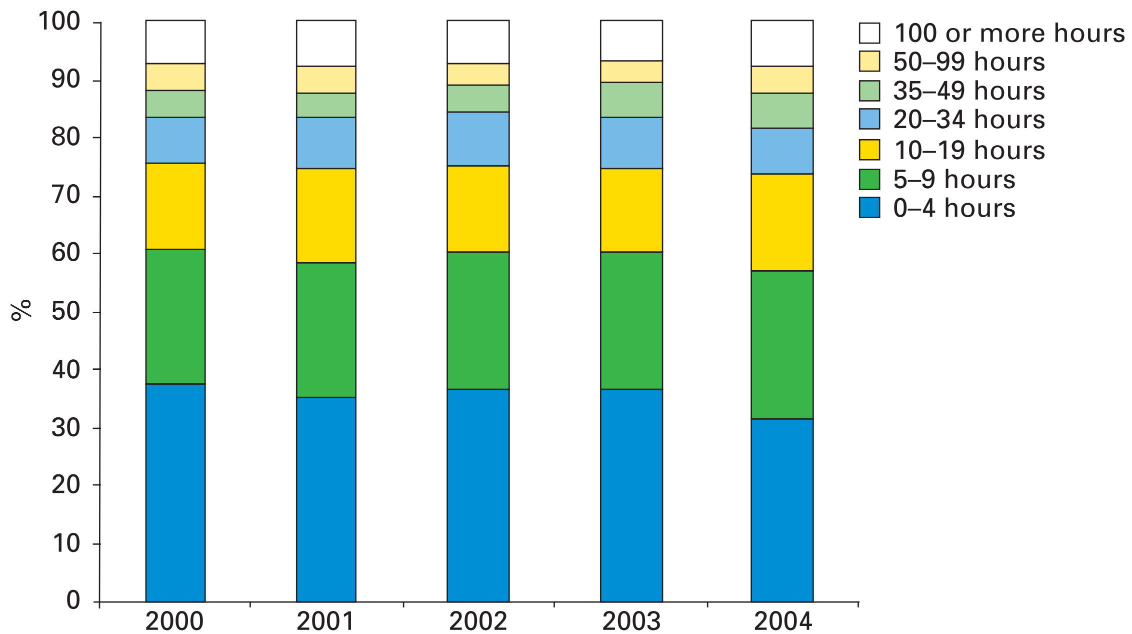
Figure 5 Number of informal carers: Scotland and rest of UK, 1998–2004



Source: Family Resources Survey.

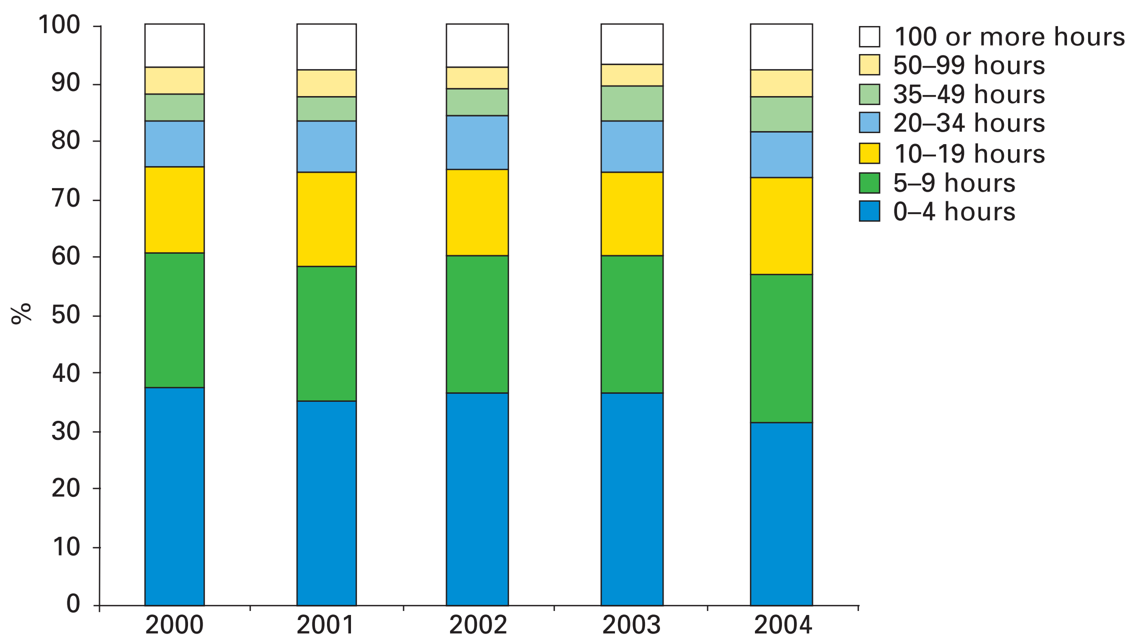
But perhaps it is not the number of informal carers that has been affected by the policy, but rather the hours of care that they supply? Figures 6 and 7 show the distribution of hours of care supplied in Scotland and the rest of Great Britain respectively between 2000 and 2004. There is no clear trend towards a shorter average provision of care hours in Scotland. In England and Wales, there is a slight increase in the provision of longer hours of care provision, but in Scotland, throughout the period, carers have tended to provide longer hours than England and Wales – around 60 per cent of carers in England and Wales supply less than nine hours of care per week, while only 52 per cent of informal carers in Scotland supply less than this amount.

Figure 6 Distribution of hours of care: Scotland



Source: Family Resources Survey.

Figure 7 Distribution of hours of care: England and Wales



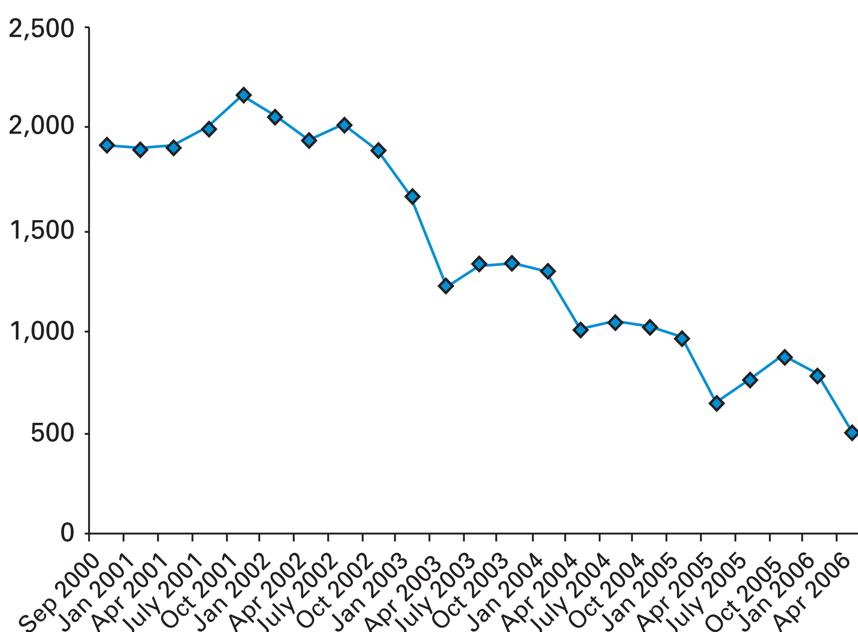
Source: Family Resources Survey.

Thus, there is no strong evidence that a decline in the quantity of informal caring has been a major source of the increased demand for personal care observed in Scotland between 2002 and 2005. This quantity is measured either in terms of the hours of care or of the number of relatives and friends providing informal care. We should add one qualification to this conclusion, however. We have some evidence that informal carers may continue to care, but are now providing different forms of care than was previously the case. This qualitative change in the tasks performed by some informal carers was noted by a number of local authority interviewees and is discussed in more detail in Chapter 2. Thus, frail older people may now be receiving more care as a result of the policy, with the informal carers adapting their provision around provision by social services. This clearly enhances the overall quality of care, but also increases the requirement for social service provision.

Switch from health care to social care expenditures

Is increased expenditure on personal care partly the result of the success of the delayed discharge policy? Figure 8 shows the number of patients waiting more than six weeks for placement. In 2006, there were around 1,500 fewer delayed discharges across Scotland than there were in 2001. This reduction has been achieved partly through better organisation of care home and care at home strategies for dealing with those recovering from hospital episodes.

Figure 8 Number of patients waiting more than six weeks for placement



Source: Scottish Executive Community Care Statistics.

However, the increase in demand for personal care both at home and in care homes has been much larger than the reduction in the stock of delayed discharges. Hence, while improved handling of delayed discharge can explain some of the increased demand for personal care, its magnitude appears to be small. The transfer of costs from the health service to social services is not always accompanied by an appropriate resource transfer. Hence the cost of care for older people may appear to be rising when viewed purely from a local authority perspective, but may be falling when one takes the more global perspective including health care costs.

There is one caveat, however. We have focused on the changes in the *stock* of delayed discharges. There may have been an increase in the *flow* of older people through the hospital system and thereafter into social care. Part of the delayed discharge policy has been to guarantee those leaving hospital upto six weeks of free care if required. We do not have information on the costs of these care packages. They are not part of the free personal care policy but illustrate its interdependence with other policies and how it is difficult to correctly identify the true resource costs of the policy.

To conclude this section, we have established that the rapid increase in the demand for personal care in Scotland cannot be explained by:

1 demographic change

2 increased levels of disability among older Scots

3 reductions in the quantity of informal caring.

Possible explanations that may go some way to explain the increase are:

1 revelation of unmet need from those who were not previously local authority clients

2 changes in the behaviour of informal carers to providing different services for the care clients.

The delayed discharge policy may have moved some costs from health care to social care and had an impact therefore on personal care costs, but these are difficult to identify without a detailed analysis of the numbers of older people passing through the hospital and social care systems. Further research in this area is essential.

In the next section, we investigate the distribution of the increase in demand by local authority and the funding supplied by the Scottish Executive to try to determine how

far the changes in demand (and apparent excess demand, i.e. waiting lists) are driven by differences in local authority social care policies and practices and the funding allocation they have received from the Scottish Executive. As we discussed earlier (see the section on 'Direct impacts' in Chapter 2), this is a key issue from local authorities' points of view.

Heterogeneous local authorities?

We now examine changes in demand at a local authority level. In our previous report,[2] we commented on the variation among local authorities in relation to social care outcomes. This heterogeneity is even more apparent now (and is reflected in issues such as waiting lists, see Chapter 2 and the discussion on accessing free personal care). We first discuss outcomes by local authority in respect of care homes and then for care at home.

Care homes

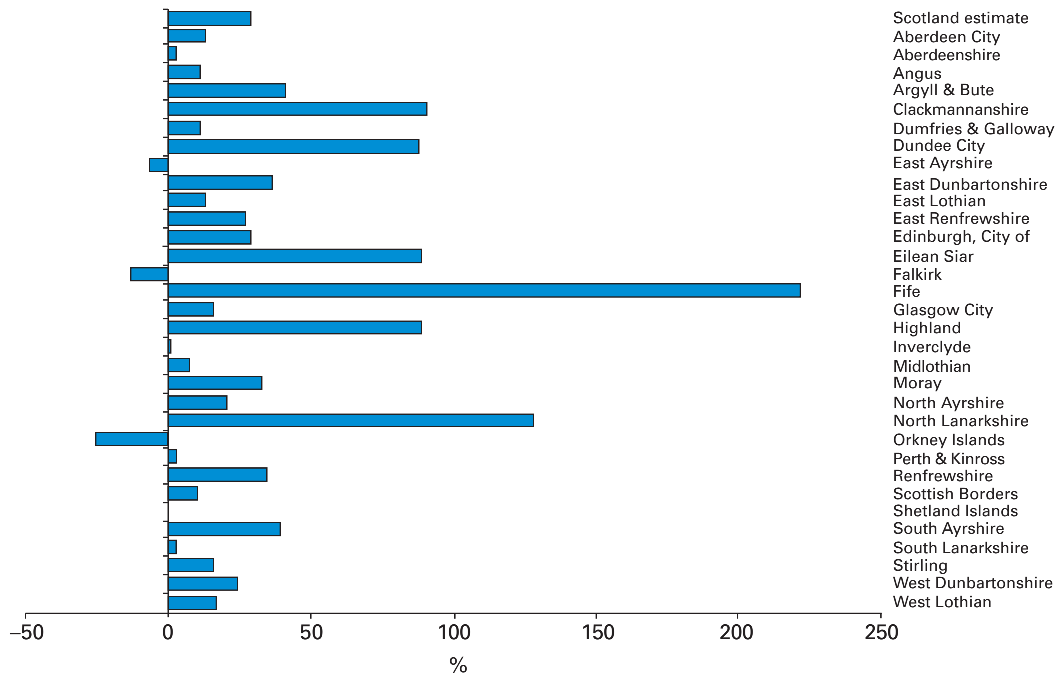
- The provision of free personal care in care homes has increased in most local authorities in the period 2002 to 2005, although there is substantial variation in the increase in provision between local authorities.

- The increased provision of free personal care in care homes has coincided with a gradual fall in the number of care home residents in Scotland. This implies that care home residents' care needs are increasing and also reflects the increased provision of care at home.

- The proportion of care home residents that are self-funding and require free personal care increased from 20 to 26.4 per cent over the period from 2002 to 2005. These people would formerly have paid for personal care and now no longer do so, increasing calls on the public purse. They continue to pay their 'hotel' costs.

Figure 9 shows the growth in provision of free personal care in care homes for each local authority in the period 2002–05. There is substantial variation in the increase in provision between local authorities.

Figure 9 Percentage growth in number of self-funders receiving FPC in care homes by local authority, 2002–05

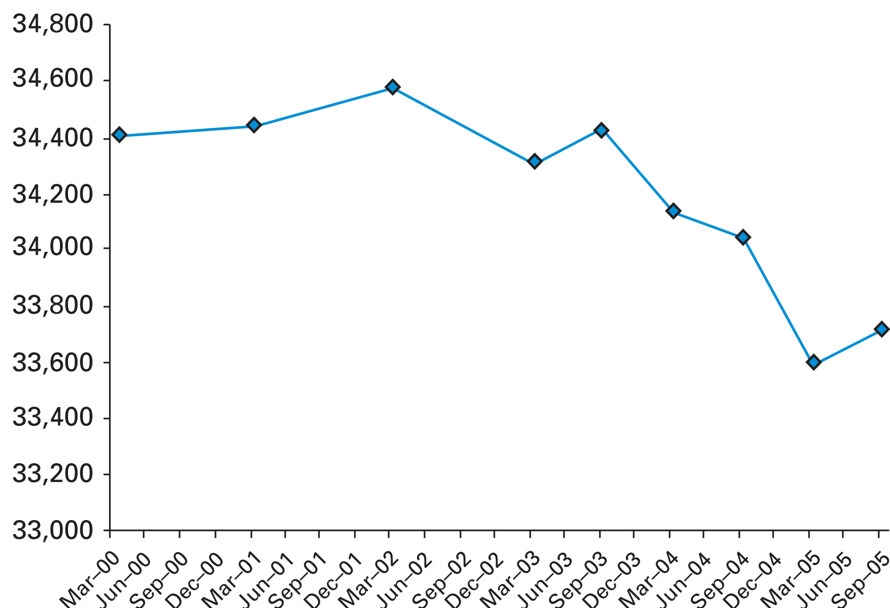


Source: Scottish Executive Community Care Statistics.

Fife has experienced increases of over 200 per cent, while there has been a decline in the neighbouring local authority of Falkirk. Some of the local authorities located in relatively poor areas, such as North Lanarkshire, started with a small number of self-funders; hence a large percentage increase may represent only a small rise in numbers.

The increased provision in care homes has taken place at a time when the number of care home residents in Scotland has been falling gradually (see Figure 10). This decline was not predicted by the Care Development Group (CDG) when making its forecasts of the demand for personal care among care home residents. Equally, the CDG failed to predict the increase in the proportion of residents that would be self-funding and require personal care. The CDG report[3] implicitly suggests that, in 2002, 7,600 care home residents (around 19 per cent of all residents) would be self-funding and require personal care.

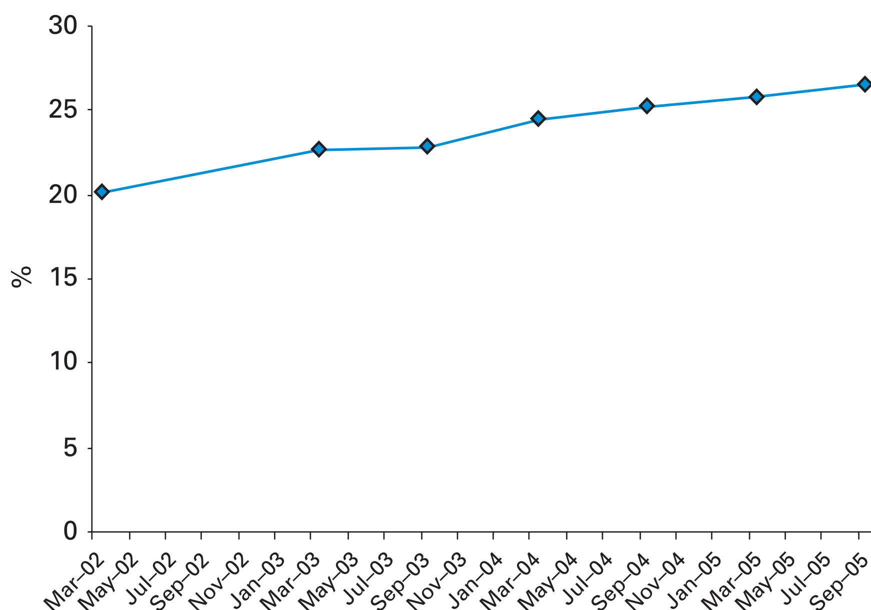
Figure 10 Care home residents in Scotland, 2000–05



Source: Scottish Executive Community Care Statistics.

Figure 11 shows how the proportion of care home residents that are self-funding and require free personal care increased between 2002 and 2005. The share has increased from 20 per cent, which was closely in line with the original CDG estimate, to 26.4 per cent by 2005. This increase was not factored into the CDG cost predictions.

Figure 11 Change in proportion of care home residents that are self-funding, 2002–05



Source: Scottish Executive Community Care Statistics.

Why has there been an increase in the proportion of self-funders in care homes? There are two possible explanations. First, the reduction in local authority and voluntary care home places may have tilted the balance in favour of private sector care homes, which may have a preference for self-funding residents. Between March 2000 and September 2005, there was a decrease of 1,227 in the number of local authority and voluntary care home residents, while the number in the private sector increased by 540. The overall decline in places may partly explain increase in pressure to provide care at home, but the increase of 540 in private care home residents is insufficient to explain the rise of almost 2,000 in the number of additional self-funders between July 2002 and September 2005.

The other explanation is that there has been an increase in the average net worth of care home residents, reflecting increases in home ownership rates in Scotland in recent decades. Increased home ownership means that individuals are more likely to have assets in excess of £12,500 and therefore are required to make some contribution towards their hotel costs in a care home. It also increases the chance of care home clients having assets in excess of £21,000. Such clients are expected to fully self-fund their care home ‘hotel’ charges.

The importance of the increased net worth explanation is difficult to establish, since we have no information on the financial circumstances of care home clients in Scotland. Nevertheless, combined with the shift towards private sector care home provision, it is a plausible explanation of the increase in FPC in care homes. However, given that increases in home ownership across Scottish local authorities have been broadly uniform, this explanation does not explain the substantial variation between local authorities in the growth of self-funding care-home residents shown in Figure 9 earlier in this chapter.

Care at home

- It appears that local authorities have reversed the decline in their overall provision of care at home and focused it towards personal care as a result of the introduction of free personal care.

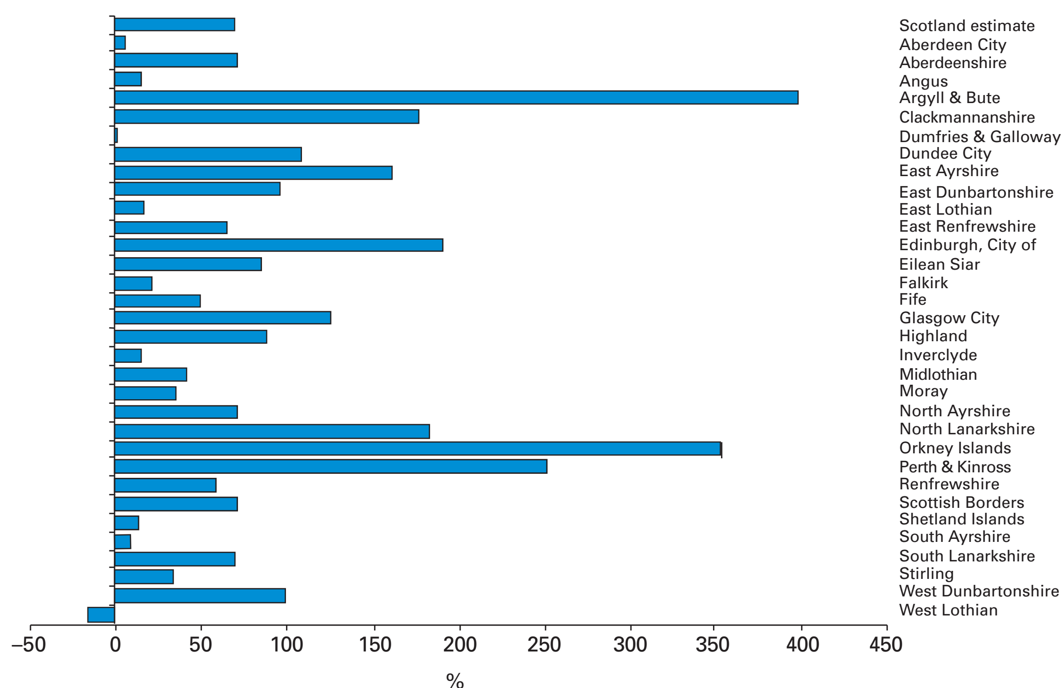
- Although there is wide variation in the increase, local authorities are providing significantly more personal care at home than they have done in the past. Available data suggest that there has been a concurrent reduction in the provision of non-personal domiciliary care, which may have been made up partly by increased private or informal provision.

- There is significant variation in the amount that authorities claim to spend on their home care clients. The most plausible explanation for these differences seems to lie in the historic social care policies of the different local authorities and the relative difficulty that they have therefore encountered in meeting the new demands caused by the introduction of free personal care.

While the number of care home residents receiving free personal care has certainly risen faster than was expected at the time the CDG report was written, the more substantial increase has been in the number of clients receiving free personal care at home.

As is clear from Figure 12, there is no obvious pattern in the growth of 15,000 in the number of home care clients receiving FPC across local authorities between 2002 and 2005. The changes by local authority range from an *increase* of 400 per cent in Argyll and Bute to a *decline* of 5 per cent in West Lothian.

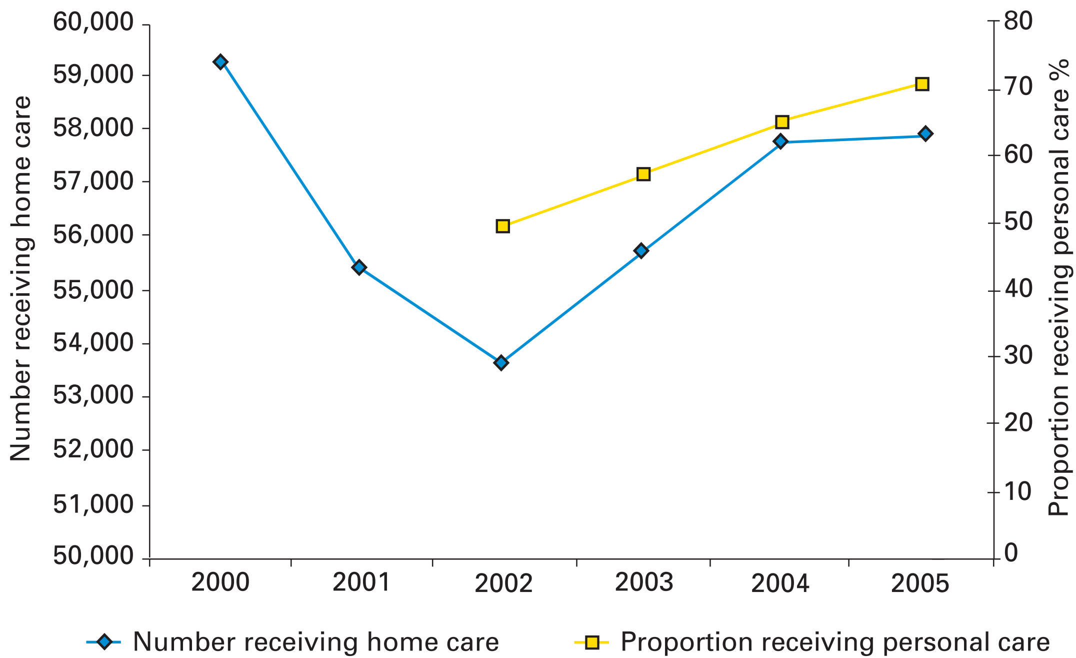
Figure 12 Growth in provision in free personal care at home, by local authority, 2002–05



Source: Scottish Executive Community Care Statistics.

It is clear that the overall number of clients receiving home care declined between 2000 and 2002 (Figure 13) but increased steadily thereafter. One of the objectives of the FPC policy was to increase care provision at home. But the overall increase in home care clients between mid-2002, when FPC was introduced, and September 2005 was only 4,500, too small to explain the increase in clients receiving FPC at home. However, one factor can explain this apparent discrepancy: the proportion of clients receiving personal care as part of their domestic care package has risen. In 2002, 50 per cent of social care clients received FPC but, by 2005, this share exceeded 70 per cent.

Figure 13 Number of clients receiving home care and proportion receiving personal care, 2000–05



Source: Scottish Executive Community Care Statistics.

This change in the nature of social care provision at home is demonstrated in Table 1, which shows the increasing proportion of home care clients receiving overnight or weekend services. Such increases are very likely to be associated with personal care and are also likely to be costly.

Table 1 Per cent of home care clients receiving 'out-of-hours' services

	2003/04	2004/05
Receiving a service during evening/overnight	24.3	27.2
Receiving a service at weekends	48.3	53.9

Source: Audit Scotland.

Thus, as a result of the introduction of FPC, it appears that local authorities have reversed the decline in their overall provision of care at home and also focused it more closely on personal care. It follows that their provision of other domiciliary care has declined; whether this has been supplanted by increased private or informal provision of other domiciliary care is not clear. However, this switch might be explained by a substitution of other domiciliary care for personal care by informal carers. This finding is consistent with our argument that the number of informal carers in Scotland has not changed significantly. However none of these arguments explains the massive variation between authorities in the growth of FPC at home.

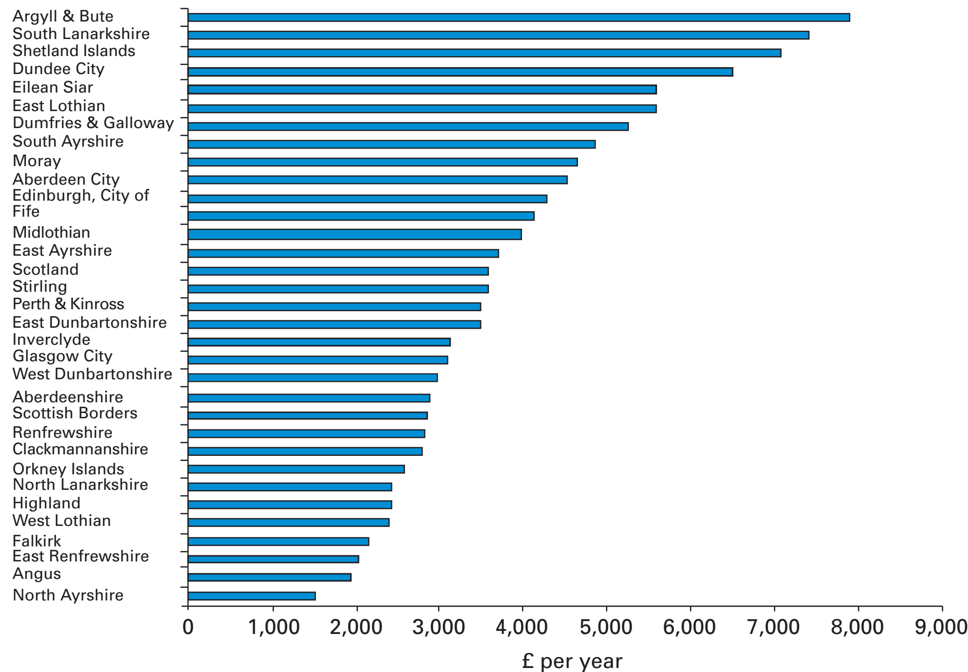
The huge variation in the amount that authorities claim to spend on free personal care at home per client is shown in Figure 14. The range between the most expensive (Argyll and Bute – nearly £8,000 per year) and least expensive (North Ayrshire – £1,500 per year) is more than five to one. It is difficult to envisage what circumstances would lead to such huge differences in costs between local authorities carrying out the same legal duty across a range of clients who do not differ substantively in their needs or conditions. Neither are the differences systematic – they do not show any clear geographical or deprivation pattern. The most plausible explanations are that they depend on the following.

1 Historic social care policies of the different local authorities and the relative difficulty that they have therefore encountered in meeting the new demands caused by the introduction of FPC. This finding echoes the qualitative explanations offered by local authority interviewees on differences in the observed abilities of different authorities to cope with the demands of free personal care.

2 Differences in the efficiency and scope of provision. Clearly, from the Scottish Executive's perspective, there is a need to understand these differences so that those that can perhaps be ascribed to differences in client characteristics or geography can be separated from differences in the efficiency of provision.

Such information would seem essential to help the Executive determine how it should allocate funding to support free personal care. In a crude sense, some of this information is embedded in the current allocation mechanism to support policies for older people – the GAE system. We now examine this issue.

Figure 14 Annual expenditure per client on free personal care at home, 2004–05



Source: Scottish Executive, Community Care Statistics.

Grant Aided Expenditure

- We find no relationship between the increase in the number of home care clients between 2002 and 2005 and the increase in GAE for home-based services to older people from 2001/02 to 2005/06. While the majority of authorities have experienced a greater increase in demand than in their GAE, GAE has exceeded the increase in demand in a number of local authorities.

- Waiting lists are likely to emerge because of insufficient funding in those authorities where the increase in demand has exceeded the increase in GAE and the authority does not reallocate other budgets towards home care.

- The allocation of GAE does not explain why there has been such rapid expansion of demand in particular authorities. But it does explain why some of these authorities have subsequently been unable to meet the demands to provide free personal care that have been placed on them.

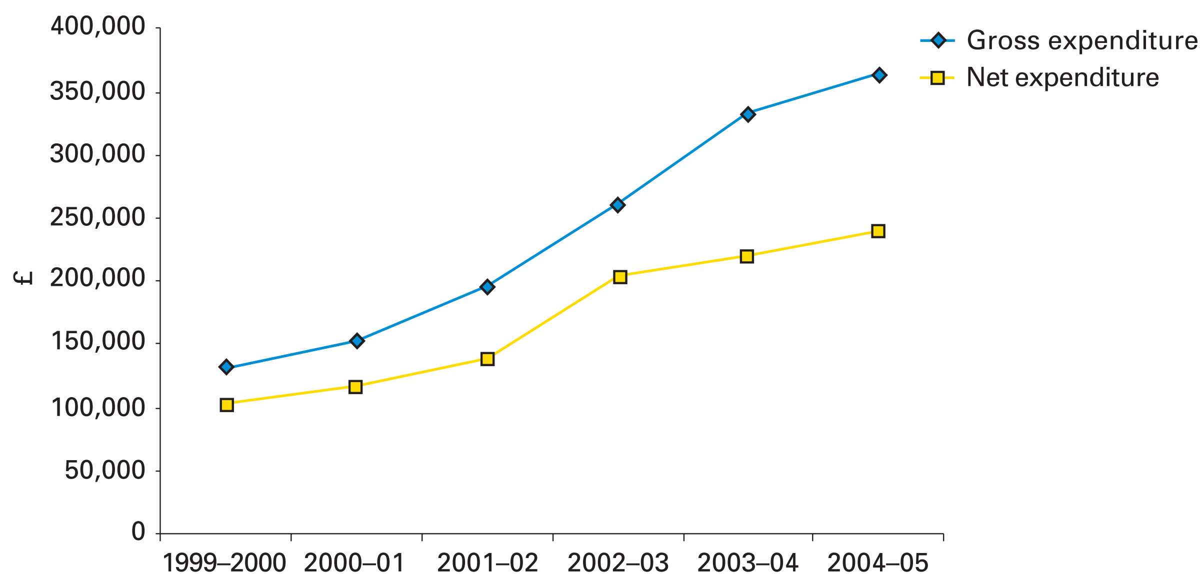
- Local authorities that had previously followed quite different policies for older people discovered that they were confronted by quite different cost implications when they found that they had a legal obligation to provide free personal care. The consequences of these differences have been significant, but were unforeseen.

As explained in the section on 'Direct impacts' in Chapter 2, Grant Aided Expenditure (GAE) is not the funds provided by the Scottish Executive, but rather represents a provision to spend. The Executive uses GAE as an estimate of the cost of providing a particular service and as the basis for calculating the amount of Revenue Support Grant, i.e. the actual financial support provided by the Executive to local authorities. Thus, while based on the GAE, the Revenue Support Grant takes into account the expected revenue that each council will generate from council tax.

The value of the GAE is agreed by the Executive in consultation with the Convention of Scottish Local Authorities (COSLA). It is based on a set of indicators that reflect difference in the costs of provision of different services.

Figure 15 shows the rapid rise in spending on home care by local authorities from 1999/2000 to 2004/05. The gross cost has risen to over £350 million, while the net cost is just less than £250 million.

Figure 15 Gross expenditure on home care by local authorities, 1999/2000 to 2004/05

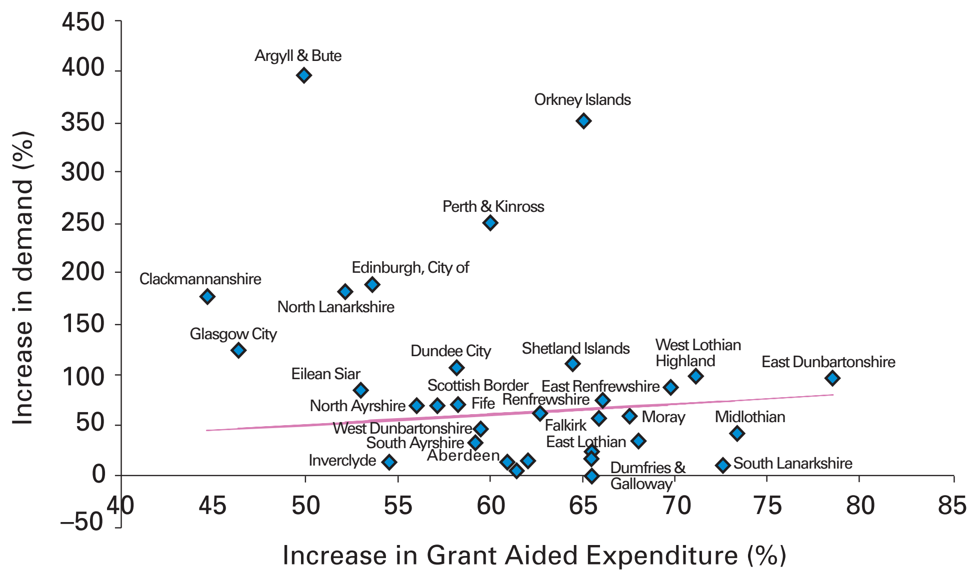


Source: Scottish Executive Community Care Statistics.

These increases in spending have been supported by increased GAE for home care. But, as we have seen earlier, the percentage increase in demand has varied greatly by local authority. Has the percentage increase in GAE matched the increased demand that we have already described? Figure 16 plots the increase in the number of home care clients between 2002 and 2005 against the increase in GAE for home-based services to older people from 2001/02 to 2005/06. There is no

relationship between these increases. Those authorities that have experienced the largest increase in demand for personal care at home have not necessarily received the largest increase in GAE and vice versa. The solid line in the figure plots those points where the percentage increase in the number of clients and the percentage increase in GAE are equal. While many authorities lie above this line, and therefore have experienced a greater increase in demand than in their GAE, there are also a number of local authorities where the increase in GAE has exceeded the increase in demand.

Figure 16 Increase in demand for personal care at home and increase in GAE for home care by local authority, 2002–05



In those authorities where the increase in demand has exceeded the increase in GAE, and where the authority does not reallocate other budgets towards home care, waiting lists are likely to emerge and the authority is likely to complain of inadequate funding.

So why does GAE not reflect the increase in demand? This is likely to partly reflect limited understanding of the demand for social care at the local level caused by lack of investment by local authorities and the Scottish Executive in social care information systems. We referred to this issue in our previous report[4] and under the heading 'Data issues' in Chapter 2.

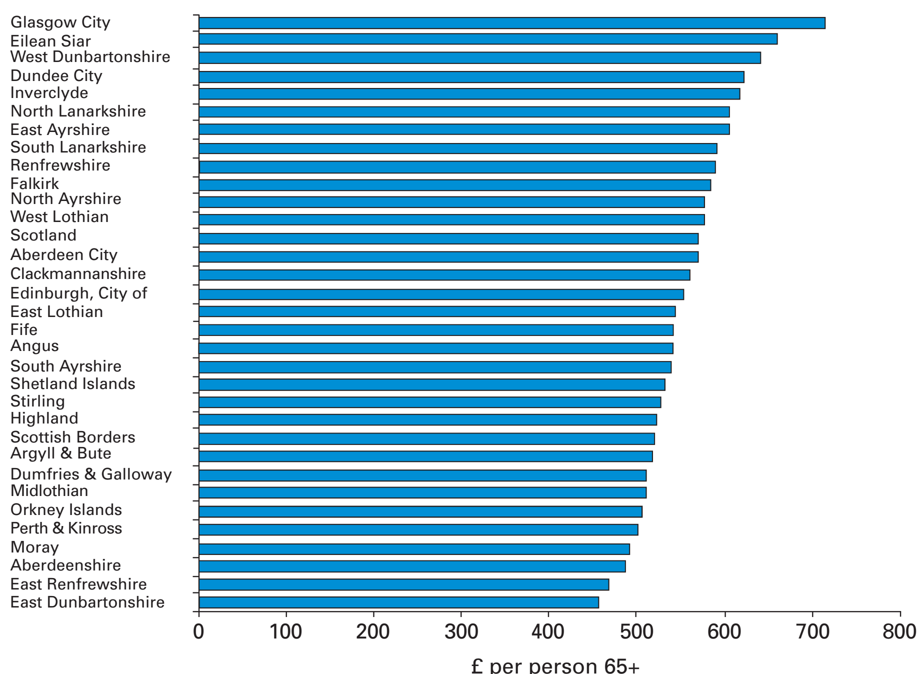
The allocation of GAE does not explain why there has been such rapid expansion of demand in particular authorities. But it does explain why some of these authorities have subsequently claimed that the costs of providing FPC were excessive.

One explanation of the increase in demand goes back to the situation prior to the introduction of free personal care, where different local authorities pursued quite different social care policies. In particular, some, such as West Lothian, had already effectively introduced FPC before the Scottish Executive legislated for it. Hence this local authority has had little difficulty in adjusting to the new policy.

It is also important to remember that this argument has nothing to do with the policy offsetting charges that those with chargeable income would otherwise have had to pay. Rather it is about the provision of free personal care to all that require it, irrespective of means. Thus the GAE for home care reflects issues such as deprivation rather than numbers of self-funding residents.

This is illustrated in Figure 17, which shows that the allocation for home care is greater in areas of high deprivation, such as Glasgow, Dundee, West Dunbartonshire and Inverclyde. This allocation implies that those authorities where there were large numbers of clients who contributed to their care costs prior to the introduction of the policy and where there is relatively low deprivation are likely to find it difficult to meet the expansion in demand.

Figure 17 GAE for home care per person aged 65+ by local authority



To conclude: the GAE system provides indicative levels of spending for different local authorities. It does not take account of the history of local authority social care policies. Relative to the changes in demand across local authorities that we

have described, the differences in GAE provision are small. This suggests that local authorities that had previously followed quite different policies for older people discovered that they were confronted by quite different cost implications when the legal obligation to provide free personal care was placed on them.

The costs of the policy

- Substantial increases in the costs of personal care provision at home provide the main explanation of the overrun in free personal care expenditure.

- Cost overruns in providing free personal care at home are, in turn, driven by differences across local authorities in the implementation of policies to extend the provision of personal care to clients in their own homes. Some authorities appear to be containing costs, while others are not.

- Cost overruns seem to reflect local idiosyncrasy rather than long-term trend. Nevertheless, reducing the variation in local authority spending on free personal care at home presents formidable managerial and political challenges. In their own financial interests, local authorities should seek to emulate best practice elsewhere. For their part, the Scottish Executive must increase efforts to collect accurate data on costs and play a stronger role in harmonising costs across local authorities by ensuring that best practices are more widely adopted.

- There is a need for further research to identify this best practice, which results both in the provision of high-quality services and the containment of costs.

We finally consider the overall costs of the policy. Table 2 presents the:

1. Care Development Group estimates of the future costs

2. Scottish Executive Health Department (SEHD) estimates of future costs presented to the Scottish Parliament Audit Committee in November 2004

3. Scottish Executive's estimates of the actual costs of the policy from July 2002 to April 2005; these are based on local authority estimates of the costs that they have incurred in implementing the policy.

Table 2 Actual and projected costs of the free personal care policy

Element of the policy	Care development cost projections[1]				SEHD projections November 2004[2]				Outcomes[3]		
	2002 £m	2003 £m	2004 £m	2005 £m	2002/03* £m	2003/04 £m	2004/05 £m	2005/06 £m	2002/03 £m	2003/04 £m	2004/05 £m
Personal care payments for residential home residents	14	14	14	16	17	23	23	24			
Personal care payments for nursing home residents	22	22	22	25	26	35	36	37	56.2	62.6	65.4
Nursing care payments for nursing home residents	16	16	16	18	12	16	16	17	16.2	17.7	18.9
Total payment for nursing and residential home clients	52	52	52	59	55	74	75	78	72.4	80.3	84.4
Clients previously charged for care by local authority and clients previously buying their own care from the private sector	20	21	21	23	15	21	21	22			
Shift from informal to formal care	8	17	25	28	6	17	25	26			
Meeting unmet need for personal care	8	17	25	27	6	17	25	26			
Personal care services in the community	36	55	71	78	27	55	71	74	92.6	116.3	135.7
Non-recurring investment in community care services	37	19	0	0	25	15	0	0			
Total expenditure on free personal care at home	73	74	71	78	79	125	142	148			
Total cost of policy	125	126	123	137	107	143	147	153	165	197	220
Overspend relative to Care Development Group projections										56%	79%
Overspend relative to SEHD projections 2004										37%	50%
Overspend on home care compared to CDG estimate										111%	91%

* This figure is for nine months only, 1 July (when the policy began) to the end of the financial year.

Note: components may not add to totals because of rounding.

1 Source: Care Development Group (2001) (based on calendar rather than financial years).

2 Source: Scottish Executive Health Department (SEHD) for Scottish Parliament Audit Committee, November 2004.

3 Source: Scottish Executive, Community Care Statistics, March 2006.

Table 2 also shows the cost overspends of the estimated actual expenditure relative to the previous projections. It is clear that these overruns have been very substantial. For example, the estimated costs in 2004/05 were 79 per cent higher than the CDG estimates. The overruns compared with the 2004 SEHD projections were smaller largely because of the additional information on potential costs that was accumulated by SEHD between 2001 (when the CDG report was published) and 2004.

Recall from our previous analysis of the Attendance Allowance (AA) data that the costs in Table 2 overstate the total public sector costs of FPC. The costs presented in Table 2 are those borne by local authorities that are largely funded by grant-in-aid from the Scottish Executive. They do not take account of any savings being made in the Scottish Executive's health budget as a result of closer integration of health and social care for older people. Neither do they account for the resources saved by the DWP because AA is no longer available to self-funding residents in care homes in Scotland. Assuming that self-funding residents are at the higher rate of AA support, the DWP will save about £29 million in 2006/07 by this mechanism. The Scottish Executive will largely have to compensate for this reduction in support.

A more detailed analysis of Table 2 shows that the main cost overrun has been in the delivery of FPC at home. Nevertheless, the increase associated with care home residents has also been significant. The CDG estimated the costs of personal care in care homes in 2005 at around £41 million. The final figure for 2004/05 was £65.4 million. Assuming that all self-funding residents in long-term care receive free personal care, the share of self-funding residents in the care home population has risen quite rapidly since 2003, when 23.6 per cent were self-funding. By 2006, 28.5 per cent came within this category.

As we have discussed, the increase in the proportion of self-funders may arise from the increased wealth of older people in Scotland. It may also reflect the change in the structure of care home provision, with a much larger proportion of care homes in the private sector and a preference that these may have for self-funding clients. This will make sense if these homes can either contain the costs of personal (and nursing) care within the £145 (£210) weekly budget or if they can increase their prices to ensure that their costs are at least covered.

There may have been implicit changes in assessment procedures that have made an assessment of a need for personal care more likely because those carrying out the assessment are aware of its financial significance to the client. Local authority interviewees provided qualitative support for this, indicating that service users, informal carers and in some cases private care providers are increasingly working with those carrying out assessments to maximise the care package. However, there is no way of empirically testing this argument at present.

The main explanation of the overspend in the FPC budget lies in the substantial overrun of the costs of personal care provision at home. If the problem had been one of demographic change or disability, one would have expected the same rates of increase in costs for both care homes and care at home. But, as can seen from Table 2, the level of care at home costs in 2003/04 and 2004/05 averaged just above 100 per cent more than the CDG had estimated, whereas the care homes overrun was 48 per cent over the same period. In turn, the cost overruns in providing FPC at home are driven by differences across local authorities in the implementation of policies to extend the provision of personal care to clients in their own homes. Some authorities appear to be containing costs, while others are not.

The hopeful part of this account of FPC is that cost overruns seem to reflect local idiosyncrasy rather than long-term trend. Nevertheless, there are clearly formidable difficulties, both managerial and political, in reducing the variation in local authority spending on FPC at home. These certainly include increased effort to collect accurate data on costs; they also perhaps suggest that the Scottish Executive should play a stronger role in harmonising costs across local authorities by ensuring that best practices are more widely adopted. Clearly, it is in the financial interest of local authorities to emulate best practice elsewhere.

An example of good practice

As Figure 14 earlier in this chapter shows, West Lothian Council is among those spending the least amount of money per client on care at home. However, there is significant evidence that this low spending is accompanied by high-quality services. In a separate study,[5] we explored the relative performance of West Lothian using Audit Scotland performance indicators, as well as conducting qualitative research with local front-line staff and clients.

The performance indicators place West Lothian in the first five Scottish local authorities in respect of nine of 16 indicators, implying a very good performance. The best indicators include care at home for people with dementia, single rooms in care homes with ensuite facilities, services during evenings and weekends, and overnight services.

The qualitative research demonstrated widespread positive views about the quality of services provided, as well as evidence that the services were supporting people effectively at home to maintain their independence, choice and quality of life, thus achieving policy goals shared by Scottish local authorities.

West Lothian therefore appears to have achieved control of costs alongside good quality of services. This has been done in the context of a radical review of services, which resulted in reorganisation and delivery of care at home supported by smart technology. The decisive factor in the quality achievements appears to have been this whole system review and the development of innovative ways of delivering services including the smart technology, but also multidisciplinary staff teams, housing with care for people with higher care needs and an effective system of intensive support for people leaving hospital. Prior to the introduction of free personal care, West Lothian had already removed charges and thus the impact of the policy was further lessened. It is likely that in cases where, for example, councils were using care charges as a significant source of revenue, and where service delivery practices had not been reviewed and modernised, the costs of free personal care and the increases in demand would have been more difficult to control, though we cannot establish this firmly without further research.

4 Conclusions and implications

The policy of free personal care has attracted intense scrutiny. It has become a flagship policy, inextricably linked to the fortunes of devolved government in Scotland. This may have resulted in unusual attention being paid to issues that may equally arise in connection with other policies and in other parts of the UK on care and support of older people. There is a need to recognise that other policies have not received the level of scrutiny that free personal care has and to be cautious in drawing any conclusions that may imply it is any more problematic than other policies. In addition to our previous report for JRF, there is a continuing Scottish Executive evaluation now in progress,[1] and free personal care was among the concerns of the Scottish Parliament Health Committee Care Inquiry.

In Scotland, free personal care continues to have general public support. Fifty-nine per cent of Scots believe that personal care should be paid for by Government and 68 per cent would pay an extra 1p in the pound income tax to finance spending on personal care.[2]

Against this background, our research has generated a number of substantive conclusions that have implications for improving delivery of free personal care.

The demand for care

Following the introduction of free personal care, there has been a Scotland-wide increase in demand for care at home and especially for personal care. There has been a 62 per cent increase in provision of free personal care at home during the first three years of the policy. Our research has shown that this cannot be explained by higher numbers of older people, higher rates of disability or reductions in the quantity of informal care. We have suggested that the increased demand may result partly from a shift away from health care towards social care for older people and partly from the emergence of previously unmet need. This unmet need appears to come principally from people who were not previously local authority clients.

The delivery of care

Statistical evidence shows that the quantity of informal care has not changed, but there is some evidence that informal carers are changing the tasks they perform, away from personal care. This too may serve to increase demand for free personal

care at home, while also increasing the quantity of care that an older person may receive. However, there continue to be no systematic data available on what tasks informal carers actually do and on the choices that may be made in the context of the availability of free personal care.

Some of the gaps in supply resulting from higher demand are increasingly being met by a growing private sector, which also facilitates more flexible service provision. It is likely that private sector growth in Scotland can be attributed to the increasing demand for services, which has come alongside the implementation of free personal care.

Perceptions of free personal care

There is continuing misunderstanding of free personal care in many areas. Local authorities report that members of the public and elected members frequently take it to mean that all care is free and this leads to complaints about legitimate charges, including 'hotel' charges.

The meal preparation issue, which we highlighted in our previous report, has proved persistent and is (October 2006) the focus of potential court action. Local authorities report that there is still significant uncertainty and several indicated that they would welcome a judicial decision to guide their actions. The often well-publicised differences between local authorities in approach to, and actions taken in relation to, current and past charging as a result of this uncertainty have served to further complicate matters for members of the public.

Issues of equity are still on the agenda. The policy is perceived to have benefited many older people with care needs, but also to have either directly or indirectly disadvantaged certain groups. It is widely regarded as inequitable and discriminatory in limiting eligibility to those aged 65 and over with care needs. Budgetary constraints experienced by authorities are seen as limiting further service development for other client groups within community care.

The impact on local authorities

The reporting of underfunding for free personal care was widespread, involving nearly all local authorities. There was a general welcome for the emergence of statistical data that will allow levels of provision to be clearly understood. Prior to the introduction of free personal care, no attempt was made to accurately cost personal

care. However, the lack of an adequate baseline for its costs has proved problematic in evaluating its cost-effectiveness.

We provided evidence that the main explanation for the overrun in the free personal care budget lies in the substantial overrun of the costs of free personal care provision at home. These are, in turn, driven by differences across local authorities in the implementation of policies to provide care at home, with some authorities containing costs more successfully than others. We suggested that cost overruns seemed to reflect local idiosyncrasy rather than long-term trend.

We demonstrated that there is no relationship between the increase in the number of care home clients and the increase in GAE for home-based services to older people since the introduction of free personal care. We suggested that, unless other budgets were reallocated, waiting lists were likely to emerge in authorities where increases in demand had exceeded the increase in GAE. We argued that allocation of GAE does not explain rapid increases in demand in particular authorities following the introduction of the free personal care policy, but does explain the inability of some authorities to meet new demands. We found that local authorities that had previously followed quite different policies for older people discovered that they were confronted by quite different cost implications when they found that they had a legal obligation to provide free personal care.

We noted the heterogeneity of local authorities in terms of increases in provision of free personal care in care homes, increases in the provision of personal care at home and the amounts that local authorities claim to spend on their home care clients. We felt that such differences were best explained by local authorities' divergent historic social care policies having strongly influenced the relative difficulty that they have encountered in meeting new demands resulting from the introduction of free personal care. There is clear evidence that some local authorities have had more success than others in controlling expenditure while retaining a higher quality of services.

Implications

The present study, as we have noted, sheds light on the consequences for local authorities and service users of delays in addressing repeatedly identified problems with its implementation. The policy of free personal care was considered in June 2006 by the Scottish Parliament Health Committee Care Inquiry. The Final Report of the Inquiry was published in June 2006.[3] Many of the specific problems with the implementation of the policy identified by the Care Inquiry were identified as

issues by our original research for JRF[4] and this follow-up study indicates that these issues remain just as problematic for local authorities. In particular, participants in this study, in common with the Health Committee, have all raised concerns with the allocation of funding to local authorities to pay for the free personal care policy. They have discussed the failure of the Scottish Executive to provide decisive leadership and unambiguous guidance on issues such as assistance with the preparation of meals. They have indicated continued and widespread misconceptions over what the policy entails. The Health Committee also considered the equity of the policy and its sustainability, questions over which interviewees for this study equally have serious concerns. The Health Committee Care Inquiry Final Report makes a number of specific recommendations in relation to the future operation of the policy.

Data collection issues need to be addressed. Statistical data about the provision of free personal care in the context of the wider universe of care provision are now starting to appear, and should make it possible to produce a much clearer picture of care provision for older people in Scotland and to provide a new baseline from which future monitoring and analysis can proceed. There is a need to set out more clearly what is covered by these data and to collect them in a more systematic fashion, reducing the level of uncertainty that local authorities feel when completing the returns and supporting the robustness of subsequent analysis. For such robust analysis to be produced there is a need for local authorities to supply data in a consistent fashion and for a focus on the key indicators of demographics, disability rates and overall costs. Within the Executive, this may require a rebalancing of statistical resources towards social care and away from areas that are less policy relevant.

The financing of free personal care at the local authority level needs to be reviewed. Many of the difficulties in implementing the policy of free personal care are linked with issues concerning local authority finance. Our findings suggested significant discrepancies in the ability of local authorities to deliver free personal care in that, for some, it had proved manageable, whereas others had generated significant deficits and had had to cross-subsidise care for older people from other budgets. We have suggested that many of these difficulties are the outcomes of a cumulative, path-dependent history, whereby local variations in service arrangements have had unforeseen outcomes when free personal care was introduced. A review of arrangements for financing local government, which included scrutiny of the GAE and thoroughly reviewed issues around whether ring-fencing is appropriate, might enable some of these historically produced problems to be addressed.

It is important for good practice to be identified and for lessons to be learned by all local authorities. For service users, clearly there is a demand for services. There is

also evidence that increases in demand may result in only people with the highest levels of need receiving support, with less intensive services being reduced. Measures that may promote the more effective supply of services are therefore to be welcomed. Some authorities are able to provide high-quality services with low relative expenditure. It is in the financial interests of all authorities to understand how this can be achieved and where possible to emulate best practice elsewhere.

Finally, the quality of available information on the free personal care policy needs to be improved. There is a clear need for better information and guidance for local authorities on the free personal care policy. Service users need better information at the point of engagement with services, so that they are accurately informed about entitlements and processes. The wider public has been offered press coverage that has been less than accurate and clearer press briefings may also go some way towards improving knowledge of the policy.

Conclusion

Therefore, in our view, the evidence shows that free personal care can be successfully implemented by local authorities, although we note that there continue to be wide regional variations in expenditure per client. Different charging regimes prior to the introduction of free personal care may go some way to explaining post-implementation differences in local authorities' abilities to keep free personal care spending within budget. Quality of services is another key issue. However, there is a lack of evidence about whether additional spending by local authorities has a direct impact on improving quality of services. Recent research[5] shows that, where local authorities have undertaken whole system reform, this can have a positive impact on the provision of high-quality services, while keeping costs under control. Where examples of good practice exist, there should be more strategic attempts to share such practice with other local authorities and with service providers.

Overall, we note continued levels of satisfaction from older people and their carers who access free personal care – although local authority delays in assessment and confusion over meal preparation continue to be problematic.

Notes

Executive summary

1 Delayed discharges occur when patients ready for discharge cannot leave hospital because the other necessary care, support or accommodation for them is not available. Recent policy has aimed to reduce numbers of older people experiencing delayed discharge by improving provision for those leaving hospitals through short-term provision of intensive support at home.

2 'Hotel' costs can be thought of as the normal costs of living, such as accommodation, food and utilities, and specifically excluding nursing and personal care. In Scotland, care home residents are required to pay for living costs or 'hotel' costs out of their own resources, subject to a means test.

3 Scottish Centre for Social Research (2007).

4 Those who had been assessed as having the means to contribute towards the cost of care.

Chapter 1

1 Bell and Bowes (2006).

Chapter 2

1 The development of Single Shared Assessment (SSA) began with the proposal in the Final Report of the Joint Future Group that there should be a 'single, shared assessment' (Joint Future Group, 2000, para. 4.7). Scottish Executive Circular CCD8/2001, Guidance on Single Shared Assessment of Community Care Needs (Scottish Executive, 2001) sets out what is to be understood by single shared assessment together with the key steps necessary to achieve its implementation. The objectives of SSA are to avoid duplication of needs assessment across different agencies and, in doing so, to make services more quickly available to users.

2 The context for developing CHPs was set out in the White Papers *Partnership for Care* (NHS Scotland, 2003) and *Delivering for Health* (NHS Scotland, 2005). *The Community Health Partnerships (Scotland) Regulations 2004* and accompanying Statutory Guidance (Scottish Executive, 2004) provide detail on CHP structure and function.

3 Audit Scotland (2006).

4 Scottish Executive Health Department and Chief Executive, NHS Scotland (2002).

5 GAE is the Scottish Executive's view of what all the local authorities need to spend on local services to meet their statutory obligations. The Scottish Executive estimates the total amount that all local authorities will require to meet their commitments and then determines what proportion of the GAE each authority should receive. Grants made in respect of GAE allocations represent a large proportion of local authorities' incomes. The distribution of GAE among local authorities takes account of a range of factors that affect spending needs, including: population and population dispersion; school pupil numbers; measures of relative deprivation and crime rates; and Standard Mortality Rates. Although the GAE allocates amounts under particular service headings these figures have 'indicative' status only and local authorities are in general free to allocate their available resources to different services, including free personal care, on the basis of local needs and priorities.

6 This is discussed in detail in the section on 'The costs of the policy' in Chapter 3.

7 http://www.scottish.parliament.uk/business/committees/health/reports-06/her06-10-vol01-00.htm.

8 http://www.scottish.parliament.uk/business/committees/health/reports-06/her06-10-vol01-00.htm.

9 http://www.scotland.gov.uk/Publications/2006/09/responsecareinquiry.

10 http://www.scotland.gov.uk/Publications/2006/09/responsecareinquiry/Q/Page/2.

11 The Community Care (Direct Payments) (Scotland) Regulations 2005 extended eligibility for Direct Payments from 1 April 2005 to people over the age of 65 who need care and attention arising out of age or infirmity. This means that every person assessed as requiring free personal care is now entitled to elect to receive

payments that they can use to directly employ others to provide this element of their assessed care needs in preference to local authority provided care and support services.

12 'Rurality' includes both settlement morphology – for example, whether a settlement is classed as a city, town, village or scattered dwellings – and the wider geographic context in which a settlement is located, i.e. whether the wider area is classed as 'sparely populated' or not. The concept of 'rurality' is embodied in the definition of 'rural' adopted by the Office for National Statistics, which can be found at www.statistics.gov.uk/geography/nrudp.asp.

13 Bowes *et al.* (2006)

14 See Chapter 3, section on 'Informal caring', on changes in informal caring since the introduction of free personal care.

15 Bell and Bowes (2006).

16 http://www.scottish.parliament.uk/business/committees/health/reports-06/her06-10-vol01-02.htm#AnnexeA.

17 Bell and Bowes (2006. p. 63).

18 Scottish Executive Health Department (2002).

19 Scottish Executive Health Department (2003).

20 Scottish Executive Health Department (2004).

21 http://www.scottish.parliament.uk/business/committees/health/reports-06/her06-10-vol01-00.htm.

22 Available at http://www.sehd.scot.nhs.uk/publications/DC20060525freecare.pdf.

23 Bell and Bowes (2006).

24 Pensions Analysis Directorate (2006).

25 Pensions Analysis Directorate (2006).

26 http://www.statistics.gov.uk/cci/nugget.asp?id=1268

Chapter 3

1 Bell and Bowes (2006).

2 Bell and Bowes (2006).

3 Care Development Group (2001, p. 46).

4 Bell and Bowes (2006).

5 Bowes *et al.* (2006).

Chapter 4

1 See Bell *et al.* (2006); Scottish Executive web page on free personal care current research, available at http://www.scotland.gov.uk/Topics/Health/care/17655/research. The report of the second phase of the evaluation is published as Vestri (2007).

2 Scottish Centre for Social Research (2007, Q412 and Care Tax).

3 Health Committee, 10th Report 2006 (Session 2): Report on the Care Inquiry. SP Paper 594 (available at http://www.scottish.parliament.uk/business/committees/health/reports-06/her06-10-vol01-00.htm).

4 Bell and Bowes (2006).

5 Bowes *et al.* (2006).

References

Audit Scotland (2006) *How the NHS Works. Governance in Community Health Partnerships – Self Assessment Tool*. Edinburgh: Audit Scotland (available at http://www.audit-scotland.gov.uk/publications/pdf/2006/HNHSWorks_Governance.pdf)

Bell, D. and Bowes, A. (2006) *Financial Care Models in Scotland and the UK*. York: Joseph Rowntree Foundation (available at http://www.jrf.org.uk/bookshop/eBooks/1859354408.pdf)

Bell, D., Bowes, A., Dawson, A. and Roberts, E. (2006) *Establishing the Evidence Base for an Evaluation of Free Personal Care in Scotland*. Edinburgh: Scottish Executive (available at http://www.scotland.gov.uk/Publications/2006/06/29093046/0)

Bowes, A. and McColgan, G. with Bell, D. (2006) *Smart Technology and Community Care for Older People: Innovation in West Lothian, Scotland*. Edinburgh: Age Concern Scotland

Care Development Group (2001) *Fair Care for Older People: Care Development Group Report*. Edinburgh: Scottish Executive (available at http://www.scotland.gov.uk/library3/health/cdgr.pdf)

Joint Future Group (2000) *Community Care: A Joint Future*. Edinburgh: Scottish Executive

NHS Scotland (2003) *Partnership for Care*. Edinburgh: Scottish Executive

NHS Scotland (2005) *Delivering for Health*. Edinburgh: Scottish Executive

Pensions Analysis Directorate (2006) *The Pensioners' Incomes Series 2004/5*. London: DWP (available at http://www.dwp.gov.uk/asd/asd6/pensioners_income.asp)

Scottish Centre for Social Research (2007) *Scottish Social Attitudes Survey, 2005.* SN. 5617. Colchester: UK Data Archive

Scottish Executive (2001) *Guidance on Single Shared Assessment of Community Care Needs*. Circular CCD8/2001. Edinburgh: Scottish Executive

Scottish Executive (2004) *The Community Health Partnerships (Scotland) Regulations 2004 and Guidance.* Edinburgh: Scottish Executive

Scottish Executive Health Department (2002) *Implementation of Free Personal and Nursing Care – Guidance*. Circular CCD4/2002. Edinburgh: Scottish Executive (available at http://www.show.scot.nhs.uk/sehd/publications/CC2002_04.pdf)

Scottish Executive Health Department (2003) *Free Nursing and Personal Care – Consolidated Guidance*. Circular CCD5/2003. Edinburgh: Scottish Executive

Scottish Executive Health Department (2004) 'Free personal care guidance', letter issued on 24 September to clarify charging for assistance with food preparation (available at http://www.scotland.gov.uk/Topics/Health/care/17655/24Sept)

Scottish Executive Health Department and Chief Executive, NHS Scotland (2002) *Delayed Discharges in Scotland. Report to the Minister for Health and Community Care.* Edinburgh: Scottish Executive (available at http://www.show.scot.nhs.uk/sehd/publications/dc20020305delaydisch.pdf)

Vestri, P. (2007) *Evaluation of the Operation and Impact of Free Personal Care.* Edinburgh: Scottish Executive Social Research

Appendix: Research methods

Qualitative methods

The analysis is based on interviews with 11 different local authorities and with a representative of the Care Commission. The local authorities interviewed comprise the five authorities that took part in the earlier research (Bell and Bowes, 2006) together with a further six selected to represent a broad range of different urban, suburban and predominantly rural populations and geographies. The same interviewees were approached for those authorities included in the earlier research. In the other six local authorities, the initial approach was to Directors of Social Work and Community Care or their equivalents, with an invitation to delegate participation to others where they felt this to be appropriate. Several did so, inviting us to interview colleagues with more direct managerial responsibilities for older people's care services. Others invited colleagues from their own or from the authorities' finance departments to join them for the interview. Interviews took place at the local authorities' offices. The maximum number of interviewees was three.

The interviews were semi-structured. Interviewees were provided with a schedule of general topic areas, but were invited to add to those as they saw fit. The local authority interviews covered: interactions between free personal care and other policies; the impact of the policy on the local authority; perceived consequences of and reactions to free personal care; local issues around the operation of the policy; and other recent and potential future policy developments. In addition to these topics, the Care Commission interview specifically asked for comment on issues that had been raised by local authority interviewees. Interviews generally lasted for around an hour and a half and were tape-recorded and subsequently transcribed for analysis.

Quantitative methods

Data sources used for quantitative analyses:

- Government Actuary's Department
- General Register Office Scotland
- Department for Work and Pensions.

Statistical sources referred to in quantitative analyses:

- Scottish Executive Community Care Statistics
- Family Resources Survey.