SUPPORT FOR SIGHT LOSS

A GUIDE TO ACTION

for

A NATIONAL REHABILITATION FRAMEWORK

By

Fred Reid

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Foreword

by Lord Low of Dalston

Some 50 years ago, I produced for the National Federation of the Blind the twelve-point plan for welfare or social services for people with sight loss referred to in this report. It proceeded from a framework of public policy and sought to exemplify best practice. In truth, in keeping with the spirit of the times, it espoused a welfare model of provision. 50 years on, thinking has moved on and now espouses a model based more on rights. That updated emphasis is reflected in this report. It argues that, where UK legislation tends to conceive of social provision in terms of welfare rather than rights, we should rather take our cue from the UN Convention on the Rights of Persons with Disabilities (CRPD), which speaks of rights to live independently and be included in the community.

The other important thing to say about this report is that, authored by Professor Fred Reid, a leading light in the Federation for over 50 years, it distils the thinking of people who are blind or partially sighted themselves. As such it is particularly deserving of attention. It makes clear that, whereas what is needed is a national framework of rehabilitation, universally available and free of charge at the point of need, rehabilitation support has always been a postcode lottery. It therefore maintains that the Federation should call for a national rehabilitation framework, inscribed in UK law as a human right, to guarantee vision rehabilitation to everyone wherever they live in the united kingdom. This report provides a basis for such a demand which cannot be ignored.

Colin Low

(Lord Low of Dalston CBE).

# AUTHOR'S PREFACE

The purpose of this report is to provide a guide for the National Federation of the Blind (NFB) in pursuit of its campaign for a national rehabilitation framework for people with significant sight loss. Access to vision rehabilitation services in Britain today is a postcode lottery, yet these services will be indispensable to all of us in time of need.

This is the final draft of the report, which I have prepared for consideration by NFB. I wish to acknowledge my indebtedness, first to the valuable writings of historians on the subject of the welfare state. My debts to them are acknowledged in the bibliography appended at the end of the Guide.

I am also greatly indebted to colleagues and friends who read earlier drafts and commented perceptively on them. I particularly wish to thank Dr. Philippa Simkiss, formerly Director of Research at the Royal National Institute of Blind People (RNIB); Mr. Simon Labbett, Chair of the Rehabilitation Workers Professional Network; Mr. Terence Moody formerly of the Department of Economics at Glasgow University; Prof. Iain Bruce formerly Director General of RNIB; Mr. Gordon Brown, formerly Prime Minister of the United Kingdom; Mr. Richard Bignell, formerly Head Teacher, Exhall Grange School, Coventry; and Mr. Paul Gillett, Vice Chair of East Sussex Association of Blind & Partially Sighted People. Special thanks are due to Prof. Anna Lawson, School of Law, University of Leeds, who thoroughly revised my penultimate draft of Part Four, of which she should be regarded as joint author. Finally, I would like to thank Mr. David Newman for proofreading this report on a voluntary basis.

Final responsibility for any errors or omissions rests, of course, with me.

The recommendations of this Guide have benefitted markedly from valuable RNIB reports on The Care Act 2014. As will be seen, the first of these reports appears to have exerted some influence on the drafting of the Act without, however, ending the long-standing persistence of the postcode lottery of which RNIB complained. That persistence is fully documented in this Guide and the reasons for its continuing endurance are explained.

In summary, Part One of this Guide sets out the need for vision rehabilitation. Parts Two and Three show that access to statutory vision rehabilitation services, first introduced one hundred years ago by The Blind Persons Act of 1920, has always been a postcode lottery. No apology is made for the space devoted to this historical retrospect. The reasons for the persistence of the postcode lottery can be fully understood only in the context of the changing pattern of the welfare state in Britain.

Part Four examines the postcode lottery prevailing today under The Care Act 2014 and reviews the persuasive explanations that have been offered for its persistence.

Finally, the Conclusion sets out recommendations for the construction of a national rehabilitation framework on the basis of rights rather than welfare.

This framework, it is argued, should be a key component of the long-awaited Green Paper to review the future of adult social care. This conclusion has been reached in the belief that the questions of short- and long-term care are inextricably linked, as many others have recognised. Rehabilitation and other measures of short-term care are fundamental to the maintenance of independence and a significant means of reducing the need for, and overall cost of long-term residential care.

Before taking leave of this text, an explanation is due on the important matter of language. Some of the expressions used in this Guide belong to a bygone era and are no longer acceptable in current discourse. Nevertheless, their use in historical analysis is unavoidable, since such language is itself part of the societal discrimination which people with disabilities have had to contest. I have therefore endeavoured throughout the report to indicate the defunct character of such terms by placing them in inverted commas.

Fred Reid, Hon. Prof. of History, University of Warwick,

September, 2020.

# EXECUTIVE SUMMARY

Paras. 1.1-3

People with serious sight loss are not a vanishingly small proportion of the British population. The number of those registered by local authorities as blind or partially-sighted may be misleading in this regard. Research by The Royal National Institute of Blind People (RNIB), suggests that, mainly due to the ageing of the UK population, the number of people with significant sight loss could rise to 2.7 million by 2030 and to 4 million by 2050.

paras 1.4-10

Significant sight loss may occur at any age between birth and end of life. It requires the support of professional workers qualified in vision rehabilitation if we are to achieve the highest possible level of personal independence and a full and satisfying life in the community.

In the light of the facts disclosed, it is recommended that NFB should call for a national rehabilitation framework, inscribed in UK law as a human right, to guarantee vision rehabilitation to everyone wherever they live in the United Kingdom. Incredible as it may seem, such a universal rehabilitation service has never been available, although Britain has had welfare services for ‘the blind' since 1920 and a welfare state since 1948. The shocking truth is, as demonstrated in Part Two of this report, that access to rehabilitation support has always been a postcode lottery.

Paras 2.1.1-5

The Blind Persons Act of 1920 was the first attempt in Britain to create a statutory system of welfare for people with serious sight loss. It indicated the possibility of a national framework of rehabilitation, universally available and free of charge at the point of need.

Unfortunately, it did not succeed in creating this and the aim is still to be fully realised.

Nevertheless, the Act had enduring strengths, namely:

(i) a loose definition of 'blind', which allows today for the inclusion of people with significant sight loss.

(ii) by writing the language of 'welfare' into legislation and making it the responsibility of every local authority, the Act signalled the intention that the new statutory service should be universal.

(iii) the Act pointed forward to rehabilitation, by providing for employment in sheltered workshops, education in residential schools for the blind, care of the elderly blind in residential homes, and the promotion of home visiting services, delivered by professionally qualified 'home teachers of the blind'

Another enduring consequence of the Act was that local authorities found it necessary to maintain a 'register of blind persons' resident in there area. Registration revealed that earlier estimates of the numbers of 'the blind' were serious under-estimates. As registration proceeded, it revealed a very large pool of blind people living in isolation, excluded from employment and any form of income support other than the meagre doles of charity.

Despite its enduring significance, however, the Blind Persons Act had weaknesses as well as strengths. The chief weakness was its permissiveness, which allowed local authorities to devolve responsibility for the delivery of blind welfare services to local charities. The scale of the problem revealed by registration ensured that these could not all cope with the problem of funding even the limited services that could be offered at the time.

Permissiveness and pressure of increasing numbers ensured that blind welfare developed as a postcode lottery, since well-endowed charities could fund blind welfare more generously than others less well-endowed. The tripartite system of funding that developed after 1920 – local taxation, supplemented by grants from central government and subscriptions from charitable donors – was not designed to counteract this tendency.

Paras 2.1.6-8

Before and after the passing of the Blind Persons Act, the National League of the Blind (a trade union which organised workers in sheltered workshops) had argued, with the support of the wider Labour movement, that home teaching services should be the direct responsibility of local authorities and should not be devolved to charities. The League believed that municipal services, funded by local taxation and supplemented by central government, would ensure a common standard of blind welfare throughout the United Kingdom.

This approach was rejected in 1920 as too 'socialistic' but, by the end of the Second World War in 1945, it was gathering support as public opinion turned increasingly towards 'collectivism', which inspired the creation of the welfare state in the years 1943-48. From this developed the four statutory social services: income guaranteed by national insurance; a national health service free at the point of use; a national system of free primary and secondary education; and housing provided by local authorities for affordable rent.

Paras 2.1.9-11

These services were widely thought of as 'universal', but this principle proved elusive in practice, not least in the field of health and welfare, delivered locally. These had grown up over the previous half century as a patchwork of provision delivered by an immense array of different bodies, which included those responsible for 'blind welfare'.

In 1948, there was pressure to unify this patchwork of provision into a ‘fifth social service', to be delivered by one local authority department. The National Assistance Act of 1948 stopped short of such unification, while providing for increased funding and stronger direction by central government.

Increased public funding produced pressure from within blind welfare to transfer responsibility for the service from charities to Local Authorities. Large cities began to lead the way in assuming direct responsibility for blind welfare. Even so, direct provision increased slowly and the postcode lottery persisted.

Para 2.2.2-5

During the two decades after 1948, three policy ideas emerged which supported the unification of health and welfare services. These were:

(i) criticism of the patchwork of health and welfare provision as financially wasteful and administratively inefficient;

(ii) that the welfare state should promote 'rehabilitation' (a term then coming into general use).

(iii) support for the idea that, in an increasingly complex society, the social services should be under the direction of professionally trained social workers.

These issues were taken up in the 1959 'Younghusband Report'. It drew attention to the new emphasis on rehabilitation and was critical of home teaching practice as narrow and atheoretical.

Its main recommendation was that government should fund the training of a greatly increased number of 'general' social workers, who would gradually take over delivery of social services to a wide variety of people in need.

The Report made no recommendation as to the organisation of social services and the new recruits to social work were therefore distributed through the existing patchwork of services. During the late 1950s and early 1960s, however, support grew for the idea of 'care in the community': the delivery of support to people in or close to their own homes.

Paras 2.2.6-7

This issue was taken up by the Seebohm Committee, whose Report (1968) recommended the establishment of a single local authority department, providing at first a family service, which would then develop into a service for the 'wellbeing of the whole community'. This would require research into other needs, such as those of disabled people.

Paras 2.2.7-10

The Seebohm Report disappointed critics on the left and right of British politics. On the left, for example, Prof. Peter Townsend criticised it as a missed opportunity that failed to identify neglected needs in the field of the fifth social service.

NFB responded to Seebohm along similar lines. As an organisation run exclusively by its blind and partially-sighted members, it could reasonably claim to understand their unmet needs. It produced a twelve-point plan, quickly dubbed a 'blind person's charter', the plan called on social services departments to introduce new services specific to sight loss and made many creative suggestions for such service, to be delivered by social workers (both generic and specialist) and by volunteers.

Paras 2.2.8-11

The NFB charter reflected the optimism of the late 1960s that a national framework of rehabilitation for people with sight loss would soon be realised. There were some grounds for this optimism in the trend of public policy. The Local Authority Social Services Act of 1970 set up Social Services Departments (SSDs) broadly on lines recommended by Seebohm. Between 1970 and 1975, Conservative and Labour governments directed significant public funds to their development, declaring their support for care in the community, which should replace long-term institutional care. To this end, central government encouraged SSDs to draw up ten-year development plans and envisaged an annual rate of funding increase for such services of up to ten percent.

Yet, when NFB presented its recommendations to the Conservative government in 1974, they were completely ignored. The general explanation for this is to be sought in the challenge to collectivism in the fifth social service, then emerging among commentators on the right of British politics and henceforth amplified by the economic decline of Britain, which began in the later 1970s and continues today.

Paras 2.1-3

This decline was met, from 1976, by calls for reduction of taxation and cuts to public expenditure. This policy began in 1977, under the Labour government of James Callaghan, but retrenchment was carried much further under the Conservative governments of Margaret Thatcher and John Major between 1980 and 1997.

Thatcher was elected in 1979 with a policy to revive the British economy by cutting taxation, shrinking the state and restoring 'Victorian values'. Faced, in 1987, with expenditure on the personal social services that continued to rise in real terms between 1980 and 1997, she decided on a policy of severe retrenchment.

Paras 2.3.4-11

The pressing issues were now the steeply rising cost of residential care for elderly people (whose numbers were growing as a proportion of the population), and the slow development of care in the community which Seebohm had suggested would reduce the cost of residential care.

These issues were taken up in a report which the government commissioned from Sir Roy Griffiths, Community Care: Agenda for Action (1988). The solution, Griffiths argued, lay, not in more funding, but in better management of the available resources.

He criticised as wasteful and inefficient the continuing division of responsibility for social care between the NHS and local authorities and the patchwork provision that still characterised the personal social services.

The solution he recommended was an end to the funding of residential care for the elderly out of NHS funds. Sole responsibility should be transferred to SSDs, which should be given the power to assess care needs, design appropriate provision and oversee their implementation.

At the same time, they should cease to be the main providers of social services and henceforth act as 'brokers' between a variety of providers: NHS, voluntary organisations, hitherto unpaid carers (usually relatives), and commercial organisations.

This reflected opinion, growing in the Conservative party since the 1960s, that 'collectivism' had worked to the detriment of social welfare. It was time to end the drift towards collectivism and restore the 'mixed economy of welfare' that had flourished (so the argument went) in Victorian times.

Significantly, these critics ignored Griffiths' advice that local authorities could not be left to fund the whole of long-term residential care. He recommended a contribution by central government of around fifty per cent. This acknowledgment that market forces must be accompanied by central government planning has been lost in much recent discussion of funding for long term care.

Paras 2.3.12-

The Conservative government enacted Griffith's other recommendations in the NHS and Community Care Act of 1990, but the results projected by Griffiths were not realised.

Over the next three decades, Conservative and Labour governments conducted a series of policy reassessments. These continued to modify the principle of collectivism, but did not end the postcode lottery which had characterised the personal social services, including rehabilitation services for people with sight loss, since 1920.

The governments of John Major continued to pursue the Griffiths philosophy, introducing, for example, Direct Payments in 1996.

The Labour government elected in 1997 under Tony Blair tried to find a compromise, a 'third way', between the market philosophy of Griffiths and collectivism. This aimed at 'modernising' the social services. The term seemed to promise universal rehabilitation services and an end to the postcode lottery. In practice, the promise again failed to be realised.

The principles of the 'third way' were criticised by a King's Fund response in 2006, which drew attention to the continuing lack of proposals to bring the NHS and local authority care into alignment, a separation which had bedevilled all attempts to create a truly universal system of health and social care since 1948.

Paras 2.3.16-17

Further legislative proposals by Labour were thwarted by the financial crash of 2008 and Labour's loss of power in the general election that followed in 2010. Meanwhile, a report of the UK Law Commission on the state of the law relating to care support identified 34 relevant Acts of Parliament which it regarded as incompatible with the human rights of disabled people.

In the wake of this report, the Conservative-Liberal Coalition elected in 2010 revisited the question in a White Paper of 2012. The foreword signed by the Secretary of State for Health, Andrew Lansley, rehearsed the shortcomings of the personal social services, highlighting especially the 'inconsistency' of provision, thus confirming the existence of a postcode lottery.

Paras 2.3.18-21

The Care Act of 2014 was presented as a comprehensive solution to this problem.

It is instructive at this point to consider the RNIB Report, ‘Facing Blindness Alone’ (2013), which drew the postcode lottery to the attention of government, as it prepared to introduce the new care legislation to Parliament. It demonstrated that some local authorities failed completely to offer rehabilitation to people with sight loss, while others delivered rehabilitation services under regulations that discriminated against people with sight loss. As a result, the number of blind and partially-sighted people in receipt of rehabilitation support had declined, in recent years, by 48%.

The report suggested that the Care Act of 2014 would provide 'a unique opportunity to ensure that blind and partially-sighted people can in the future access the rehabilitation and ongoing social care that they so obviously need'. It recommended that the Act should provide universal rehabilitation for all newly blind and partially-sighted people, based on a full community care assessment and designed to overcome 'the unique barriers to independent living' that they face.

Paras 2.3.22-25

On the face of it, the Care act 2014 appeared to respond to most of these recommendations by laying new duties on local authorities to broker short- and long-term care and support for people in their own homes, following assessment of needs and preparation of a 'care and support plan'.

Paras 3.1-12

Evidence presented after the passing of the act, however, demonstrated that its provisions were seriously undermined by austerity cuts to public expenditure, introduced as a means of checking the growth of government debt.

In 2018, The National Audit Office (NAO) reported that between 2010-11 and 2017-18, central government funding of local authority services had fallen by an estimated 49.1% in real terms. Local authorities had therefore been forced to cut short-term care services such as rehabilitation, while struggling to meet the ever rising cost of long term residential care.

An RNIB report, 'See, Plan and Provide', published in 2016, showed that 'nearly half' of all local authorities had responded by ignoring the duties laid upon them by the Care Act. In addition, ‘66 per cent of local authorities did not offer an initial specialist assessment to people diagnosed with sight loss’.

RNIB repeated its earlier recommendation that: 'Everyone with a visual impairment must receive a specialist face to face assessment, leading to a plan identifying the outcome of the assessment’.

Other sources confirm the postcode lottery revealed by 'See, Plan and Provide'. Simon Labbett, Chair of the Rehabilitation Workers Professional Network (RWPN), told NFB: 'I am aware of some areas of the country with no [rehabilitation] workers’.

A 2018 report produced by Coventry Branch of NFB drew attention to local information that, under austerity cuts, the number of vision rehabilitation staff of the local authority had been cut from 10 in 2010 to 4 in 2019.

Para 3.13

In addition to the damaging impact of austerity, entitlements to access care have been weakened and rolled back by the Coronavirus Act 2020. Schedule 12 of this Act sets out a range of obligations under the Care Act and associated regulations with which local authorities no longer need to comply. These include the need to assess an adult’s need for care. These ‘easements’ are due to remain in force until March 2022, but there is the potential for them to terminated before that time or extended further at six-monthly intervals. The extent to which local authorities have taken advantage of these ‘easements’ of their obligations is not entirely clear, but Sloan indicates that at one point before July 2020 7 or 8 local authorities had given formal notification that they would be relying on them to reduce their care provision.

The conclusion, then, is inescapable: with nearly half of all local authorities in England wholly falling down on duties towards registered blind and partially-sighted people under The Care Act 2014, it is time to end the postcode lottery. How is this to be done?

Paras 4.1.1-4

'Those who cannot remember the past are condemned to repeat it.'

Parts Two and Three of this report have shown that, over the last hundred years, the United Kingdom has repeatedly attempted to legislate for universal rehabilitation services for people with significant sight loss, only to fall back into some kind of postcode lottery.

The explanation of this cycle of repetition was suggested convincingly in a journal article by Tabitha Collingbourne, in 2014. She argued that The Care Act 2014 was 'a missed opportunity because it did not securely embed the right, inscribed in Article 19 of the UN Convention on the Rights of Persons with Disabilities (CRPD), to live independently and be included in the community’. Historically, British governments had persistently construed 'independent living and care in the community' by reference to a 'welfare' rather than a 'rights' model. The Care Act 2014 was but the latest example of this persistence.

Moreover, the Act failed to provide adequate redress mechanisms. Collingbourne described such as there were as 'monumentally opaque' and 'inadequate’ when judged against international human rights standards.

Paras 4.2.1-3

Collingbourne's analysis is based on the CRPD. This Convention is a human rights treaty which makes clear how existing human rights should be understood and implemented in the disability context.

The UK government became a party to this treaty in 2009 and thus committed itself to implementing all the rights set out in it. The UK's progress has been reviewed by the UN Committee on the Rights of Persons with Disabilities (UN CRPD Committee), whose 2016 Report took account of representation by organisations of people with disabilities.

The Committee found that austerity measures had indeed resulted in breaches of disabled people’s rights under a number of articles, including Article 19 of the CRPD. Article 19 is the right to live independently and be included in the community (which is the focus of Collingbourne’s article).

The government published a response to this enquiry which, instead of setting out plans for tackling the problems, rejected the Committee’s conclusions and insisted that there had been no breach of human rights. A year later, the UN CRPD Committee examined the UK’s progress in implementing the rights set out in the CRPD and again expressed concerns about the UK’s implementation of Article 19, the right to live independently and be included in the community.

Paras 4.2.5-8

These concerns and recommendations of the CRPD Committee on the UK’s implementation of Article 19 provide purchase for campaigns by the NFB for a national rehabilitation framework.

Three other Articles of the CRPD – 26, 20 and 4 – should also be taken into account and used in any such campaign.

The title of Article 26 is ‘habilitation and rehabilitation’. Broadly it sets out rights to access rehabilitation services which are designed to maximise the independence of a disabled person and tailored to their particular needs and circumstances.

Article 20, on ‘personal mobility’ is concerned broadly with ensuring that disabled individuals have access to the equipment, assistance, skills and training (including long canes and guide dogs) they need in order to get around independently.

Finally, Article 4 of the CRPD on ‘general obligations’ includes a number of commitments relevant to rehabilitation, including the training of professionals and staff working with persons with disabilities in habilitation and rehabilitation programmes.

Paras 4.3.1-4

The broad conclusions of this Campaign Guide are as follows:-

NFB campaign for a national rehabilitation framework must be informed both by the lessons of history and by the current disability human rights context as reflected in the CRPD and the ongoing work of the CRPD Committee.

In devising care and support plans, SSDs should be aware that rehabilitation services will often need to be combined with appropriate support provided by sighted people. Notwithstanding this recommendation, it should be fully understood that the provision of such support without rehabilitation would produce dependency rather than independence. In short, the interlocking provision of rehabilitation, support and care forms the ground upon which independence and participation will be realised.

In 2015, government undertook to produce a Green Paper setting out its proposals for the funding of adult social care. It is still awaited, though the present government included the undertaking in its election manifesto of 2019. At the time of writing this Campaign Guide, further delay has been announced on account of the coronavirus pandemic. Further delay is deeply frustrating. Whatever solution is finally proposed, however, for the funding of residential care, the Green Paper should provide an opportunity to revisit the question of the relationship between short- and long-term care. Universal short-term care (including rehabilitation)will reduce the cost of residential care.

NFB should, then, call for production of the Green Paper and, in doing so, require that the following recommendations be included:

RECOMMENDATIONS

1 The legislative enactment of a right to independence and participation.

2 A universal offer of rehabilitation for all newly blind and partially-sighted people.

3 Rehabilitation to come before a full community care assessment and be offered regardless of an individual's eligibility for long-term care.

4 Rehabilitation to be available for as long as it is needed.

5 Social care eligibility criteria that properly recognise the unique barriers to independent living that people living with sight loss face.

6 Any agreed vision rehabilitation support must start within twelve weeks of the person's initial contact with the local authority.

7 Sufficient funding to support the provision of rehabilitation, calculated by reference to the population of each local authority.

8 A fully-structured system for collection of relevant information to enable the monitoring of the implementation of rehabilitation-related aspects of the CRPD.

9 Initiatives to collaborate with other relevant disability organisations to ensure that rehabilitation-related concerns are included in future shadow reports to the CRPD Committee.

10 Effective remedies for breach of relevant CRPD requirements, either for individuals or groups and the recognition of central government's accountability for UK compliance with the CRPD.

SUPPORT FOR SIGHT LOSS

A GUIDE TO ACTION

for

A NATIONAL REHABILITATION FRAMEWORK

# PART ONE: THE CHALLENGE OF SIGHT LOSS

1.1 People with serious sight loss are not a vanishingly small proportion of the British population. In 2017 (the latest year for which figures are available), there were about 350,000 people registered as 'blind' or 'partially-sighted' in the United Kingdom. As a proportion of the total population this amounted to about 5 in every 100,000. The number may seem reassuringly small, a tribute to ophthalmic medicine and public health policy.

1.2 Yet, if we look closer, we cannot be complacent. Research by The Royal National Institute of Blind People (RNIB), shows that the number of people with significant sight loss is over two million and 'is set to increase dramatically in the future.' This is because the population is ageing and the risk of sight loss increases with advancing years. Age-related macular degeneration is by far the largest risk. Obesity, diabetes and glaucoma are also significant. Consequently, the number of people with sight loss could rise to 2.7 million by 2030 and to 4 million by 2050 (RNIB website).

1.3 The truth is, then, that those of us who live longest are at greatest risk of experiencing significant sight loss. Those who live to 70 have a one in five chance; for those who live to 90 the risk rises to fifty-fifty. Sight loss is not something that only happens to someone else: it could very well happen to you or someone you love.

1.4 Should we encounter significant sight loss, it will be at any age between birth and end of life. Whatever the age at which it happens, we will need the support of professional workers qualified in vision rehabilitation. Without this, people with significant sight loss cannot achieve the highest possible level of personal independence, which is vital to living a full and satisfying life in the community.

1.5 We have just referred to 'rehabilitation'. Some prefer the modern term ‘reablement’. Others use the term 'habilitation' to distinguish the practice that is applied to a person who has never possessed unimpaired sight. Here we mostly use the more familiar term, 'rehabilitation’, since we have in mind services for people who undergo significant sight loss later in life.

1.6 With rehabilitation support, someone with serious sight loss and even blindness can be taught 'mobility', that is to go about safely, both in and out of doors. Indoors, they can be taught to cope with stairs and other obstacles in the home and, out of doors, to go at least as far as their garden gate. Travel in the public environment can be greatly facilitated by teaching someone to use a long cane or a guide dog. Again, no one with serious sight loss need be totally dependent on family or friends for everyday care and support. A rehabilitation worker can teach them to safely make a hot drink, prepare meals and otherwise care for themselves and their homes.

1.7 According to the Office of National Statistics, nearly 8 million people in the UK are living alone and the number is rising. Among these are many of the 2 million living with significant sight loss. Rehabilitation is indispensable for them and equally for those lucky enough to share their homes with sighted companions. The person with the visual impairment rapidly gains confidence and an increasing measure of independence, while the burden of care on companions is reduced.

1.8 Finally, a professionally qualified worker can do much to mitigate the emotional impact of sight loss. It is of enormous help to anyone in that situation to know that there is someone who is on their side and who knows what can be done to make life much easier. This includes provision of information about other types of support: access to education for the young; access to employment for adults; advice and help in applying for welfare benefits such as personal independence payments.

1.9 With all this support and more in place, the sight loss journey, though never a walk in the park, can be a stimulating voyage of exploration, introducing people to new friends, new experiences and new accomplishments.

1.10 In the light of the facts disclosed above, it is recommended that NFB should call for a national rehabilitation framework, inscribed in UK law as a human right, to guarantee vision rehabilitation to everyone wherever they live in the United Kingdom. Incredible as it may seem, such a universal rehabilitation service has never been available, although Britain has had welfare services for ‘the blind' since 1920 and a welfare state since 1948. The shocking truth is, as demonstrated in Part Two of this report, that access to rehabilitation support has always been a postcode lottery.

# PART TWO: A HUNDRED YEARS OF SUPPORT FOR SIGHT LOSS

## 2.1 The origins of 'Blind Welfare'.

2.1.1 The Blind Persons Act of 1920 is historically significant as the first attempt in Britain to create a statutory system of welfare for people with serious sight loss. In aiming to provide education, employment in sheltered workshops and care for the economically inactive, it indicated the possibility of a national framework of rehabilitation, universally available and free of charge at the point of need. Unfortunately, it did not succeed in creating this and the aim is still to be fully realised. From this perspective, the Act had three provisions that were to prove enduring.

(i) Although its title referred to 'blind persons', the Act allowed, in practice, support for what we now call significant sight loss. The key to this was its loose definition of the term 'blind': a person 'so blind as to be unable to perform work for which eyesight is essential'. Though ultimately inadmissible as a test of employability, this definition rightly allowed that the disadvantages related to serious sight loss were not confined to those with total blindness. In future, therefore, welfare law and practice would reach out to partially-sighted people whose sight loss was so serious that it could not be corrected by wearing glasses.

(ii) The Act required all local authorities to submit to central government schemes to promote 'the welfare of blind people'. This mandatory character of the Act was qualified by its permissiveness, which allowed local authorities to fulfil their responsibilities either by themselves delivering services directly, or by devolving responsibility to a voluntary agency. Permissiveness notwithstanding, by writing the language of 'welfare' into legislation and making it the responsibility of every local authority, the Act signalled the intention that the new statutory service should be universal.

(iii) To this end, the Act specifically instanced the services of sheltered workshops and residential institutions for the education of blind children or the care of the elderly, but allowed also for 'such other things as may appear to them desirable'. This clause permitted the promotion of home visiting services. Home visiting had been pioneered in the nineteenth century by local charities, whose visitors were often unpaid amateurs. From 1920, the service would be delivered by qualified professional workers, called 'home teachers' of the blind, whose duties were to help clients adjust to loss of sight, by giving them emotional support and teaching braille, touch typing and handicrafts like knitting and basket weaving.

2.1.2 There was an indirect result of the Act which also proved enduring. To carry out its provisions, all local authorities found it necessary to maintain a 'register of blind persons' resident in there area. This proved vital, since all previous estimates of the numbers of blind people turned out to be serious under-estimates. As registration was organised, therefore, it revealed a very large pool of blind people living in isolation, excluded from employment and any form of income support other than the meagre doles of charity.

2.1.3 The Blind Persons Act was, then, a historic landmark. Nevertheless, it proved to have weaknesses as well as strengths. The chief weakness was its permissiveness. The local charities to whom responsibility was devolved could not all cope with the problem of funding even the limited services that could be offered at the time. The main reason was the scale of the problem revealed by registration. Under the 1920 Act, people had an incentive to come forward and be registered as blind. The incentive was the provision of a 'blind pension', payable at the same rate as the old age pension dating from 1908, but at the age of fifty, rather than the general qualifying age of seventy.

2.1.4 Since blindness was a condition most commonly found in old age, older blind people now flocked to take eye tests that led to registration and entitlement. In 1920 it had been estimated that there were somewhat over 30,000 blind people in England and Wales. By 1929 there were over 52,000 registered blind people and nearly 80,000 in 1947 [Phillips, pp. 392, 413].

2.1.5 Under this pressure of numbers, blind welfare developed unevenly. Charities that were well endowed by private donations were better placed to fund home teaching, braille libraries, care homes and the like. Others, less well endowed, could provide only limited services. After 1920, a tripartite system of funding developed, but its effect was very uneven. Local authorities were given powers to subsidise blind welfare out of local taxation, but varied greatly in their willingness to do so. Central government also had powers to subsidise blind welfare, but chose to direct its funds mainly to sheltered employment and special schools for the blind. Under this tripartite system of funding, therefore, home teaching and residential care services developed as a postcode lottery.

2.1.6 This geographical unevenness of provision had long attracted criticism. Well before the passing of the Blind Persons Act, the National League of the Blind (a trade union which organised workers in sheltered workshops) had argued that home teaching services should be the direct responsibility of local authorities and should not be devolved to charities. With the support of the Labour Party and the Trades Union Congress, the League argued that local authority responsibility, developed under advice from central government, would ensure a common standard of blind welfare throughout the United Kingdom.

2.1.7 The League's approach was rejected in 1920 as too 'socialistic' but, by the end of the Second World War in 1945, it was gathering support.

2.1.8 The War had popularised the idea of 'collectivism', which inspired the creation of the welfare state in the years 1943-48. Its supporters sought to establish the principle of a universal standard of life, guaranteed by the state and inscribed in legislation for social security benefits, a National Health Service free at the point of use, free education to age fifteen and housing, constructed by local authorities for affordable rent. These came to be called the four social services.

2.1.9 The universal principle, never completely achieved in the four services, proved even more elusive in the fifth, the local health and welfare services. These had grown up over the previous half century. Responsibility was split at the centre between two Ministries – Health and Local Government – and locally between municipal and county authorities and charities such as The Red Cross. The result was a patchwork of provision delivered by an immense array of different bodies. They included asylums for the mentally ill, orphanages for children and homes for elderly people, as well as domiciliary services for people with a wide range of disabilities, including 'blind' people.

2.1.10 During the setting up of the welfare state, there was pressure to unify this patchwork of provision into a ‘fifth social service', comprising the full range of personal social services, to be delivered locally by one authority department. The National Assistance Act of 1948 stopped short of such unification. It did provide, however, for increased funding and stronger direction by central government.

2.1.11 Such an extension of services required increased and stable funding. Local taxation, subsidised by central government, promised more of this than charity could provide. Within blind welfare, therefore, pressure grew to transfer responsibility for the service from charities to Local Authorities. Large cities like London and Glasgow, began to lead the way in assuming direct responsibility for blind welfare. Even so, direct provision increased slowly. By 1959 70% of local authorities still fulfilled their statutory responsibilities by devolving them to voluntary agencies (Younghusband, par. 510). In short, the postcode lottery persisted.

## 2.2 Support for sight loss and reform of the personal social services

2.2.1 Resistance to collectivism on the right of politics after 1950 might have ensured the long-term continuity of the patchwork described above.

2.2.2 Three policy ideas emerged, however, which supported the unification of health and welfare services. These were:

(i) that the patchwork of health and welfare provision was financially wasteful and administratively inefficient, and that unification under one local authority department would remedy these defects;

(ii) that the welfare state should go beyond ensuring a minimum standard of passive existence for every citizen. It should also promote the 'rehabilitation' (a term then coming into general use) of all who encountered loss of bodily function through injury or disease. Rehabilitation was defined as their fullest possible integration into the wider community. This should be a task of the personal social services, funded out of taxation and delivered locally under the direction of central government.

(iii) With these went support for the idea that, in an increasingly complex society, the social services should be under the direction of qualified social workers, professionally trained to understand the complex causal relationship between individual behaviour and the workings of society.

2.2.3 These issues were taken up in the 1959 Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services, The 'Younghusband Report'. It drew attention to the new emphasis on rehabilitation by citing central government advice on implementation of the National Assistance Act. This directed that services should 'ensure that all handicapped persons whatever their disability should have the maximum opportunity of sharing in and contributing to the life of the community so that their capacities are realised to the full' (Younghusband, par. 263). What that 'contribution' might mean for blind people was indicated by the enlarged list of duties which central government had recommended for a home teacher of the blind, which should include 'assistance in securing employment', not just in sheltered workshops, but in 'open industry' (Quoted in Younghusband, par. 264).

2.2.4 To this end, the main recommendation of the Younghusband Report proposed that government should fund the training of a greatly increased number of 'general' social workers, who would gradually take over delivery of social services to a wide variety of people in need. It commented critically on the training of home teachers, as too narrowly concerned with teaching braille and crafts and too limited in its coverage of social work theory.

2.2.5 The Report made no recommendation as to the organisation of social services and the new recruits to social work were therefore distributed through the existing patchwork of services. During the late 1950s and early 1960s, however, support grew for the idea of 'care in the community': the delivery of support to people in or close to their own homes. This movement was fuelled by growing belief that long-stay institutions, such as 'geriatric' and ‘mental’ hospitals, were repressive in their treatment of groups such as elderly, mentally ill, mentally 'handicapped' and physically disabled people (Goffman, pp. 13-116). Another driving force was the increasing rate of juvenile crime, often attributed to family breakdown, which fuelled demand for more support for 'broken' families and the children who suffered from them. Social workers, now organised in effective professional bodies, took the lead in arguing this case (Low, pp. 265-).

2.2.6 The Seebohm Committee, appointed in 1965 to review 'Local Authority and Allied Personal Social Services', began by agreeing with the advocates of a single family service, but went further. It recommended, in 1968, the establishment of 'A new local authority department, providing a community based and family orientated service, which would be available to all', but added significantly that the new unified department should deliver 'service for the well-being of the whole community' [Seebohm, p. 11). The Seebohm report, therefore, envisaged a unified social service that would (a) address social needs comprehensively and (b) be universal, that is freely available to all at the point of need. It argued, however, that it would be impossible to meet all needs immediately. The new social service departments should begin, therefore, by organising services for families and children, while continuing to research the scope of other needs, such as those of elderly and disabled people, bringing forward plans for the organisation of appropriate services. Chapter Ten of the report was devoted to urging the need for services for people with disabilities, whose numbers had been as seriously under-estimated as those of the blind before 1920.

2.2.7 The Seebohm Report disappointed critics on the left and right of British politics. On the left, for example, Prof. Peter Townsend, one of the most articulate and high profile critics, argued that, by taking evidence exclusively from service providers and ignoring service users, the Committee failed to identify neglected needs. Consequently, it missed an opportunity of demonstrating possible new developments in the fifth social service. He offered two illustrations: (a) the lack of information for service users about their welfare rights, suggesting the use of public radio to inform them; and (b) the exclusion of many service users from normal social activities, suggesting the provision of transport to enhance inclusion. Significantly, he also allowed a large role for trained volunteers in the augmentation of social services, especially in hospitals (Townsend, p. 12, 75-78).

2.2.8 NFB responded along similar lines. As an organisation run exclusively by its blind and partially-sighted members, it could reasonably claim to understand their unmet needs. Led by Mr. Colin (now Lord Low), it produced a twelve-point plan to encourage social services departments to introduce new services specific to sight loss. As reported in the Federation's magazine, Viewpoint, this 'Blind Person’s' Charter' called on local authorities to 'keep blind people adequately informed of the services available to them, and themselves be aware of blind peoples' needs, rights and special difficulties: blind people should be given the chance to play a far greater part in the making of decisions affecting them, and imaginative help should be given in many fields including rehabilitation, mobility, transport, communication, recreational facilities, shopping, household chores and so forth'.

2.2.9 The Charter recognised a role for general social workers, responsible for service delivery across a range of needs, but pointed to the equal need for specialists, such as qualified rehabilitation workers, to teach skills vital to coping with sight loss. As the Viewpoint report put it: 'The generic social worker is to be helped out by specialist teachers, some of whom should themselves be blind, who would impart the skills of reading and writing, household management, etc., and by organised volunteers, who would give assistance with shopping, house decoration, and general repairs, and with transporting blind people to educational and social functions and the like' (Viewpoint, Autumn Issue, Sep.-Nov., 1972).

2.2.10 The Federation's Charter thus recognised the criticisms of the home teaching service made by the Younghusband Report. It also showed awareness of new developments in rehabilitation for people with sight loss. These included the teaching of new techniques, such as the use of the long cane to improve mobility; the role of the social worker as an adviser on welfare rights; and the imaginative use of volunteers to promote social inclusion. Above all, it reflected the optimism of those years that a national framework of rehabilitation for people with sight loss would soon be realised.

2.2.11 When NFB presented its recommendations to government in 1974, however, they were completely ignored. The immediate reasons for this are open to conjecture, but the more general cause is clear. It lay in the challenge to collectivism, then emerging among commentators on the right of British politics. This line of criticism was to have lasting influence and must now be considered closely.

## 2.3 Support for sight loss and the crisis of the Welfare State

2.3.1 For a few years after the Seebohm report, optimism about the future of the personal social services seemed justified. The Local Authority Social Services Act of 1970 set up Social Services Departments (SSDs) broadly on lines recommended by Seebohm. Between 1970 and 1975, Conservative and Labour governments directed significant public funds to their development. Their main aim was to replace long-term institutional care by care in the community, underpinned by such services as home helps, meals on wheels, rehabilitation, and day-care centres. To this end, central government encouraged SSDs to draw up ten-year development plans and an annual rate of funding increase of up to ten percent was projected for such development (Webb and Wistow, pp. 143, 161).

2.3.2 The severe economic crisis of the later 1970s put paid to this optimism. The rate of growth of the British economy entered a long period of decline which, with some respite between 1997 and 2007, has persisted to the present day (Pugh, Part V, pp. 419-513). It was met, from 1976, by calls for reduction of taxation and cuts to public expenditure. The first measures were undertaken by the Labour government of James Callaghan. Cuts to public expenditure ensured that funding for the personal social services failed to keep abreast of inflation and marked funding differentials opened up between rich and poor areas of the country (Webb and Wistow, pp. 167-176).

2.3.3 Between 1980 and 1997, retrenchment was carried much further under the Conservative governments of Margaret Thatcher and John Major. Margaret Thatcher was elected in 1979 with a policy to revive the British economy by cutting taxation, shrinking the state and restoring 'Victorian values'. This signalled retrenchment of the welfare state. Reform of the personal social services was delayed, however, until her third administration begun in 1987. Meanwhile, expenditure on the social services continued to rise in real terms (Low, pp. 313].

2.3.4 In the personal social services, the pressing issues were the steeply rising cost of residential care for elderly people (whose numbers were growing as a proportion of the population), and the slow development of care in the community which Seebohm had suggested would reduce the cost of residential care.

2.3.5 These issues were taken up in a report which the government commissioned from Sir Roy Griffiths, Community Care: Agenda for Action (1988). The Report noted the widespread complaints of under-funding of social services. The solution lay, Griffiths countered, not in more funding, but in better management of available resources. He criticised as wasteful and inefficient the continuing division of responsibility for social care between the NHS and local authorities and the patchwork provision that still characterised the personal social services.

2.3.6 To solve this problem, Griffiths recommended an end to the funding of residential care for the elderly out of central government funds. Sole responsibility should be transferred to SSDs, which should be given the power and resources to assess care needs, design appropriate provision and oversee their implementation. At the same time, they should cease to be the main providers of social services and henceforth act as 'brokers' between a variety of providers: NHS, voluntary organisations, hitherto unpaid carers (usually relatives), and commercial organisations.

2.3.7 This reflected opinion, growing in the Conservative party since the 1960s, that 'collectivism' had worked to the detriment of social welfare. It had made social services the near monopoly of expensive and inflexible state bureaucracies, encouraged client dependency, undermined the spirit of self-help and severely curtailed the role of voluntary action in welfare provision. It was time to end the drift towards collectivism and restore the 'mixed economy of welfare' that had flourished (so the argument went) in Victorian times.

2.3.8 Griffiths' recommendations were based on this social philosophy. He argued that transfer of responsibility to local authorities, in the way he recommended, would incentivise them to develop care in the community. Moreover, this responsibility need not be implemented by SSDs directly. They should be free to broker services for users by hiring other providers in the market place. resort to the market for service providers would often be cheaper and more efficient than statutory provision. Efficient expenditure of scarce resources, accurate targeting to those most in need, and reduction of demand for residential care would follow.

2.3.9 In responding to Griffiths' report, the Conservatives failed to pay regard to an important reservation. Griffiths was not persuaded that local authorities should be left to bear the burden of long-term residential care alone. In Para 6.3 of his report he wrote:

2.3.10 'In order to provide the necessary basis for planning and implementation of the proposals, I recommend that central government should provide directly to social service authorities, by specific grant, a substantial proportion of the total public funds it estimates are needed to meet national objectives. This might be 50 per cent, or might be slightly lower (say 40 per cent - 45 per cent) to indicate that the primary responsibility for community care should correctly lie with the Local Authority.'

2.3.11 This recognition that central government subsidy must complement the working of market forces has been lost in much recent discussion of funding for long-term care.

2.3.12 Parliament enacted these recommendations in the NHS and Community Care Act of 1990, but the results projected by Griffiths were not realised, partly because of central government restriction of local authority spending, partly because the numbers of elderly people went on rising, and partly because the cost of providing residential care also climbed steeply (Low, p. 319).

2.3.13 Over the next three decades, this failure resulted in a series of policy reassessments. These continued to modify the principle of collectivism, but did not end the postcode lottery which had characterised the personal social services, including rehabilitation services for people with sight loss, since 1920.

2.3.14 The governments of John Major, which succeeded that of Margaret Thatcher in 1990, continued to pursue the Griffiths philosophy, introducing, for example, Direct Payments in 1996.

2.3.15 The Labour government elected in 1997 under Tony Blair tried to find a compromise, a 'third way', between the market philosophy of Griffiths and collectivism. Its White Paper of 1998, ‘Modernising Social Services’, summarised the approach: 'We all need good social services to be there at … times of crisis'. It noted that often, as presently organised, they were not 'there'. There were 'too many examples of problems and failures': notably, a lack of 'consistency'. 'Social services', it continued, 'cannot be exactly the same everywhere, but a greater degree of consistency is needed.'

2.3.16 The White Paper promised to solve these problems by 'modernising' the social services. What was meant by modernisation? On the face of it, the term seemed to promise universal rehabilitation services and an end to the postcode lottery. Modernisation, the White Paper stated, meant 'supporting people's independence', protecting 'vulnerable people' and ensuring 'high quality social services' for everyone. These principles were enacted in The Health Act of 1999 but, once again, its promise failed to be realised. This was because the government relied on a 'modernisation fund' to incentivise local authorities, still operating as brokers, to reach the higher standards envisaged. No new duties were imposed to make them reach these standards and compliance was patchy because local authorities were still struggling to pay for residential care. This was inevitable after the Government rejected the majority recommendation of its own Royal Commission in 1999, that residential care should be free, like the NHS, at the point of need (Wanless, p. 8).

2.3.17 The policy of the 'third way' was revisited by Labour in a Green Paper of 2005, ‘Independence, Well-Being and Choice: Our Vision of the Future of Social Care for Adults in England’. It reaffirmed faith in the mixed economy of welfare and repeated that service delivery had to be modernised, so as to ensure: early intervention; better assessment of need and a louder voice for service users in the assessment process; reduction of inequalities of provision; and more support for people with long-term needs.

2.3.18 These principles were broadly reaffirmed in the Government's follow-up White Paper of 2006. Few dissented from them in the abstract, but the devil was in the detail of their application. A King's Fund response drew attention to the continuing lack of proposals to bring the NHS and local authority care into alignment. Indeed, the response argued that the separation, in 1948, of an NHS free at the point of use, from a personal social service subject to means testing, had bedevilled all attempts to create a truly universal system of health and social care. The White Paper was itself evidence of this contradictory thinking when it stated: 'social care is not a universal service' (quoted in Wanless, p. 19). Given this contradiction, the White Paper could make only piecemeal proposals for cooperation between the two services.

2.3.19 The proposals contained in the White Paper of 2006 were not enacted by the Labour Government. The financial crash of 2008 undermined any such intention. In that year, however, the UK Law Commission reported on the state of the law relating to care support. It identified 34 relevant Acts of Parliament which it regarded as out-of-date. These Acts favoured institutional care over care in the community and contained offensive and stigmatising language and were, potentially, incompatible with the human rights of disabled people. In the wake of this report, the Coalition government elected in 2010 under David Cameron revisited the question in a White Paper of 2012, ‘Caring for Our Future: Reforming Care and Support’. The foreword signed by the Secretary of State for Health, Andrew Lansley, rehearsed the shortcomings of the personal social services in a way that amply confirmed the existence of a postcode lottery:

2.3.20 'Across the country, the quality of care and support that people receive can vary considerably. Services that are available as standard in some places are unavailable in others … Our system of care and support, developed in a piecemeal fashion over six decades, is broken and in desperate need for reform.'

2.3.21 The Care Act of 2014 was presented as a comprehensive solution to these problems.

2.3.22 How have people with significant sight loss fared under its provisions? Before we review, in Part 3, the evidence bearing on this question, it will be instructive to consider the RNIB Report, ‘Facing Blindness Alone’. Published in 2013, this report drew the postcode lottery to the attention of government, as it prepared to introduce the new care legislation to Parliament. It registered the following concerns:-

(i) Some local authorities failed completely to offer rehabilitation to people with sight loss. Out of 128 local authorities which responded to freedom of information requests, only 114 offered this support. The number dropped to 101 if people with significant sight loss which did not meet the criteria for registration were included.

(ii) Some authorities applied highly restrictive criteria of eligibility for access to care and support. These ranged need on a descending scale from [critical' through 'moderate', to 'normal' and 'low'. In applying these criteria they excluded people with significant sight loss on the grounds that their needs did not fall into the 'critical' category.

(iii) An increasing number of local authorities were offering rehabilitation support only to people registered as blind or partially-sighted, disregarding people whose sight loss was not so severe as to justify registration, though sufficiently serious as to leave them with support needs.

(iv) Some local authorities failed to intervene with rehabilitation support in a timely way. Government guidance had recommended that no more than four weeks should elapse between registration as blind or partially-sighted and the first assessment of need for rehabilitation. The Report produced evidence of delays lasting up to four months. It pointed to the crucial role of eye clinic liaison officers (ECLOS) in guiding newly diagnosed patients through the complex pathway to rehabilitation support.

(v) Some local authorities were limiting the length of time that rehabilitation support could last to six weeks. The Report pointed out that this was based on a false comparison with time needed for recovery from quite different medical conditions, such as fractures. People with significant sight loss had much more complex needs, which not only took longer time but often required them to 'dip in and out' of training in mobility and other skills.

(vi) Among local authorities, there was a huge variation in the ratio between the number of specialist rehabilitation workers employed and the size of their populations. This could range between 1 worker per 55,000 and 1 per 683,000.

2.3.23 The cumulative effect of such practices, the Report stated, was a decline of 48% in the number of blind and partially-sighted people receiving care and support, including rehabilitation support.

2.3.24 The report suggested that the Care Act of 2014 would provide 'a unique opportunity to ensure that blind and partially-sighted people can in the future access the rehabilitation and ongoing social care that they so obviously need.' To this end it recommended that the Bill before Parliament should provide:

(i) A universal offer of rehabilitation for all newly blind and partially-sighted people.

(ii) Rehabilitation to come before a full community care assessment and be offered regardless of an individual's eligibility for long-term care.

(iii) Rehabilitation to be available for as long as it is needed.

(iv) Social care eligibility criteria that properly recognise the unique barriers to independent living that people living with sight loss face.

2.3.25 On the face of it, the Care Act 2014 responded to most of these recommendations. It laid new duties on local authorities to broker short- and long-term care and support for people in their own homes. Long-term care could include support with washing, dressing, help at meal times, throughout the day and/or night. Short-term care aimed at rehabilitation, through intensive periods of support to regain skills, confidence and independence lost as a result of illness, injury or disability.

2.3.26 Furthermore, the Act required local authorities to assess the needs of an eligible person for care and support. People with disabilities were included among those considered 'eligible'.

2.3.27 Finally, the Act required local authorities, having assessed the needs, to prepare a 'care and support plan' to meet them. This done, the authority must 'keep under review generally care and support plans' and respond to any reasonable request from an eligible person for a review of their needs.

2.3.26 In view of these new provisions, RNIB might have concluded that its campaign of 2013 had yielded beneficial results. The truth is, however, that evidence presented since the passing of the act undermines any confidence that may have existed.

# PART THREE: SUPPORT FOR SIGHT LOSS UNDER THE CARE ACT 2014: the Impact of Austerity Cuts and ‘Easements’ due to Coronavirus

3.1 The Care Act 2014 was passed at a time when, in response to the high level of public debt following the financial crash of 2008, the Coalition government under David Cameron was imposing severe 'austerity cuts' in public expenditure.

3.2 In 2018, The National Audit Office (NAO) In its 2018 report, 'Adult Social Care at a Glance', considered the effect of these cuts on adult social services. Between 2010-11 and 2017-18, it found, central government funding had fallen by an estimated 49.1% in real terms.

3.3 The report was not concerned to demonstrate the effect of austerity cuts on rehabilitation services. Rather it demonstrated that care in the community, even when delivered under the new duties mentioned above, had failed to stem the rising cost of, and demand for long-term residential care. Local authorities, that is to say, were caught in a pincer crush between austerity cuts and rising costs.

3.4 Evidence of the impact of austerity cuts on rehabilitation support for people with significant sight loss was provided by another valuable RNIB report, 'See, Plan and Provide', published in 2016. It showed that many local authorities had responded to austerity cuts by ignoring the duties laid upon them by the Care Act. 'See, Plan and Provide' was based on a survey of 150 local authorities in England. It concluded that 'nearly half [49 percent] of people with sight loss already in contact with their authorities did not receive an assessment for vision rehabilitation. Furthermore, 66 percent of local authorities did not offer an initial specialist assessment to people diagnosed with sight loss’.

3.5 In the light of these findings, RNIB called on local authorities to ensure that:

(i) Everyone with a visual impairment must receive a specialist face to face assessment.

(ii) Everyone with serious sight loss must have a plan in place, identifying the outcome of their assessment.

(iii) Any agreed vision rehabilitation support must start within twelve weeks of the person's initial contact with the local authority.

3.6 Other sources confirm the postcode lottery revealed by 'See, Plan and Provide':

3.7 Simon Labbett, Chair of the Rehabilitation Workers Professional Network (RWPN), told NFB: 'I am aware of some areas of the country with no [rehabilitation] workers'.

3.8 In April 2019, Coventry Branch of NFB produced a report, 'Support for Sight Loss: the Challenge for Coventry', which was reprinted in Fed News, the successor to Viewpoint. It drew attention to local information that, under austerity cuts, the number of vision rehabilitation staff of the local authority had been cut from 10 in 2010 to 4 in 2019.

3.9 The Branch used a freedom of information request, followed by face-to-face discussion with the council cabinet leader and senior management for social care, to establish the true facts. Forced by central government funding cuts to reorganise social care, the Council cut the number of specialist workers from 6 to 4. These 4 are now responsible for hearing as well as vision rehabilitation. Another 4 of the original 10 were clerical support staff, whose duties have been distributed across other departments as well as social care.

3.10 Due to these cuts, the Council could not claim to fully meet its responsibilities under the Care Act. With just 4 specialist staff on its Hearing and Vision Impairment Team, it could claim that people newly registered as blind are seen within one week of contact with the authority, but the Council could not demonstrate that a vision rehabilitation plan is provided for all of Coventry's 1125 registered blind people who need one.

3.11 Nor can the Council show that a vision rehabilitation plan is put in place for people with serious sight loss that does not conform to the fairly strict definition of blindness required for registration. RNIB research suggests that the number of people with significant sight loss in Coventry (including registered people) may be as high as 6000. The sight loss of such people, though partial at the time of first diagnosis, is often prone to future deterioration, so that later re-assessment of need is necessary.

3.12 We may conclude, then, that Coventry is a local authority that has striven to meet and has partially fulfilled its duties under the Care Act 2014. As the 2016 RNIB report demonstrates, however, nearly half of all local authorities in England are wholly falling down on these duties towards registered blind and partially-sighted people – to say nothing of the many others with significant and progressive sight loss. It is time to end this postcode lottery.

3.13 In addition to the damaging impact of austerity, entitlements to access care have been weakened and rolled back by the Coronavirus Act 2020. Schedule 12 of this Act sets out a range of obligations under the Care Act and associated regulations with which local authorities no longer need to comply. These include the need to assess an adult’s need for care. These ‘easements’ are due to remain in force until March 2022, but there is the potential for them to be terminated before that time or extended further at six-monthly intervals. The extent to which local authorities have taken advantage of these ‘easements’ of their obligations is not entirely clear, but Sloan (2020) indicates that at one point 7 or 8 local authorities had given formal notification that they would be relying on them to reduce their care provision.

# PART FOUR: CONCLUSION

## 4.1 The lesson of history

4.1.1 The American philosopher, George Santayana wrote, 'those who cannot remember the past are condemned to repeat it.' In Parts Two and Three of this report, we have shown that, over the last hundred years, the United Kingdom has repeatedly attempted to legislate for universal rehabilitation services for people with significant sight loss, only to fall back into some kind of postcode lottery. What is the explanation of this cycle of repetition?

4.1.2 Tabitha Collingbourne, in a 2014 journal article on 'The Care Act 2014', accepted that the Act was 'a significant improvement’ on earlier legislation but argued that it was nevertheless 'a missed opportunity because it did not securely embed the right (in Article 19 of the UN Convention on the Rights of Persons with Disabilities) to live independently and be included in the community. She argued that this was because, historically, British governments had persistently construed 'independent living and care in the community' by reference to a 'welfare' rather than a 'rights' model. The former treated social service users as passive recipients of benefits conferred by government, which could be granted or withheld. The latter treated them as active citizens with rights inscribed in law. The Care Act 2014 was but the latest example of this persistence. Its stated aim was to provide for the 'wellbeing' of people with disabilities. Furthermore, for all its inclusive language, its creation of new duties for local authorities and its insistence on the need to listen to service users when assessing their needs, it did not guarantee access to care services as a right. Thus, although the Act 'constituted a welcome transition in approach' it was, however, 'negated in practice by the government's insistence that neither the wellbeing principle nor its supporting outcomes and factors are intended to create any directly enforceable or individual rights'.

4.1.3 Accordingly, as Collingbourne highlighted, there is still no statutory right to independent living in the law of England and Wales or Scotland. Such redress mechanisms as there are for lack of adequate care or rehabilitation are what she describes as 'monumentally opaque' and 'inadequate’ when judged against international human rights standards. Indeed, problems of accessing legal advice and making complaints have intensified as a result of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO), which dramatically reduced legal aid and thus the funding on which many advice providers depend. Further, the problems associated with localisation of care provision identified in this report continue under the Care Act; and, as explained above, the impact of austerity has been particularly severe in the context of care.

4.1.4 We agree broadly with the argumentation in Collingbourne's article. History indicates that a significant reason for the persistence of the postcode lottery is that, in reforming provision for care and support, successive British governments have depended on the model of welfare at the cost of insufficient regard for the human rights of people with disabilities.

## 4.2 Human Rights

4.2.1 In 2006 the United Nations adopted a new treaty which sets out the human rights of disabled people – The Convention on the Rights of Disabled People (CRPD). This did not aim to create new human rights. Its purpose was to make it clear how existing human rights should be understood and implemented in the disability context. The UK government became a party to this treaty in 2009. This means that the UK government has committed itself to implementing all the rights set out in this treaty and its progress with this will be regularly reviewed by the UN Committee on the Rights of Persons with Disabilities (UN CRPD Committee). When the UK’s record is being reviewed, disabled people’s organisations are encouraged to work together to produce what are known as shadow or parallel reports, to give the UN CRPD Committee a fuller picture of what is happening in the UK than it would have if it relied only on the government’s account.

4.2.2 Concerns from disabled people’s organisations about the damaging impact of austerity on the human rights of disabled people resulted in the UN Committee on the Rights of Persons with Disabilities (the CRPD Committee) being invited to carry out an inquiry on the matter in 2015 and 2016. This Committee found that austerity measures had indeed resulted in breaches of disabled people’s rights under Articles 19, 27 and 28 of the UN CRPD (UN CRPD Committee, 2016). Article 19 is the right to live independently and be included in the community (which is the focus of Collingbourne’s article); Article 27 is the right to work and employment; and Article 28 is the right to social protection, which addresses issues such as disability benefits and minimum standard of living. The government published a response to this enquiry which, instead of setting out plans for tackling the problems, rejected the Committee’s conclusions and insisted that there had been no breach of the CRPD (UK Government). A year later, the UN CRPD Committee examined the UK’s progress in implementing the rights set out in the CRPD as part of its routine four-yearly examination of countries that are party to this treaty. The resulting report – the Committee’s Concluding Observations on the UK – deserves some attention:

4.2.3 In its Concluding Observations on the UK, the CRPD Committee expressed concerns about the following issues in connection with the UK’s implementation of the Article 19 right to live independently and be included in the community:

(a) The fact that the [UK’s] legislation fails to recognize living independently and being included in the community as a human right that enshrines individual autonomy, control and choice as intrinsic aspects of that right;

(b) Policies and measures that affect the ability to live independently in the community, such as the reduction in social protection schemes related to housing, household income and budgets for independent living, as well as the closure of the Independent Living Fund;

(c) The fact that responsibility for supporting independent living has been transferred to the devolved administrations and local authorities without providing appropriate and earmarked budget allocation;

(d) The fact that many persons with disabilities are still institutionalized and deprived of the right to live independently and be included within the community, when: (i) they lack the financial resources to afford personal assistance; (ii) local authorities are of the opinion that they can provide assistance within care homes; and (iii) the cost rationale constitutes the main parameter of an assessment;

(e) The lack of support services and accessible public facilities, including personal assistance, for persons with disabilities, … to live independently and be included in the community. (UN CRPD Committee 2017, para. 44).

It recommended, in line with its inquiry of the previous year, that the UK clearly recognise that living independently and being included in the community is a right, and that measures be put in place to ensure that it can be enforced by disabled people. It also recommended that adequate resources should be provided to local authorities and other bodies for discharging responsibilities placed on them to support independent living (UN CRPD Committee 2017, para. 45).

4.2.4 In relation to the right to an adequate standard of living and social protection, under Article 28 of the CRPD, the Committee also expressed a number of concerns about the UK and the impact of austerity on disabled people. For example, it stated that it was concerned about:

The negative impact on the standard of living of persons with disabilities of, among others, the reductions in social support, unemployment allowance, independence payments and Universal Credit payments and the insufficient compensation for disability-related costs. (UN CRPD Committee 2017, para. 58(b)).

Amongst the associated recommendations it issued was that the UK should:

Ensure that the budget allocation is sufficient for local authorities to meet their responsibilities regarding assistance for persons with disabilities. (UN CRPD Committee 2017, para. 59(d)).

4.2.5 While these concerns and recommendations of the CRPD Committee provide some purchase for campaigns by the NFB for a national rehabilitation framework, there are three other CRPD provisions which have particular relevance to rehabilitation and which should therefore also be taken into account and used in any such campaign. Two of these were not mentioned in the Committee’s concluding observations on the UK. The third is mentioned, but not in connection with issues relating to rehabilitation.

4.2.6 The first of these additional three rights is set out in Article 26 of the CRPD. This is entitled ‘habilitation and rehabilitation’. It reads as follows:

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

(a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;

(b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.”

This provision, which is the most directly relevant to the subject-matter of a national rehabilitation programme, has not yet had a high profile in the work of the UN CRPD Committee. It is rarely, if ever, mentioned in its concluding observations on different countries. This may well be because disabled people’s organisations and national governments are focusing more on Article 19 in their reports to the Committee. If the profile of Article 26 were to be raised in State and shadow reports, it may well be explicitly mentioned more often by the CRPD Committee.

4.2.7 The second of these three additional provisions is Article 20, which is entitled ‘personal mobility’ and reads as follows:

States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities, including by:

(a) Facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at affordable cost;

(b) Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost;

(c) Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities;

(d) Encouraging entities that produce mobility aids, devices and assistive technologies to take into account all aspects of mobility for persons with disabilities.

This right is thus particularly important to those aspects of rehabilitation that concern the acquisition of mobility aids (such as long canes and guide dogs), skills and training. While this appears to have been mentioned in concluding observations of the CRPD Committee more often than Article 26, it again has had a relatively low profile to date. As with Article 26, this relatively low profile may reflect a lack of focus on this provision in State or shadow reports to the Committee.

4.2.8 Finally, Article 4 of the CRPD on ‘general obligations’ includes a number of paragraphs which are relevant in this context. These are part of Article 4(1), according to which States that are party to the CRPD (such as the UK), “undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability”. It then goes on to specify a number of commitments States must make as part of this undertaking. These include the following:

(f) To undertake or promote research and development of universally designed goods, services, equipment and facilities, which should require the minimum possible adaptation and the least cost to meet the specific needs of a person with disabilities, to promote their availability and use, and to promote universal design in the development of standards and guidelines.

(g) To undertake or promote research and development of, and to promote the availability and use of new technologies, including information and communication technologies, mobility aids, devices and assistive technologies, suitable for persons with disabilities, giving priority to technologies at an affordable cost.

(h) To provide accessible information to persons with disabilities about mobility aids, devices and assistive technologies, including new technologies, as well as other forms of assistance, support services and facilities;

(i) To promote the training of professionals and staff working with persons with disabilities in the rights recognized in this Convention so as to better provide the assistance and services guaranteed by those rights.

These particular aspects of Article 4 were not highlighted by the CRPD Committee in its concluding observations on the UK. They are, however, relevant to rehabilitation services and access to the supports and assistance for daily living that it entails.

## 4.3 Recommendations for constructing a national rehabilitation framework

4.3.1 We are of the view that a NFB campaign for a national rehabilitation framework must be informed both by the lessons of history and by the current disability human rights context as reflected in the CRPD and the ongoing work of the CRPD Committee.

4.3.2 As indicated above, Article 26 of the CRPD recognises rehabilitation as a human right, recognising that it is fundamental to the promotion of independent living and participation in the community. While rehabilitation is undoubtedly essential to independent living and inclusion in the community, it is not alone sufficient to achieve these ends. As the 2013 report of RNIB insisted, rehabilitation must be complemented by measures of support designed to ensure that people with significant sight loss can participate in community life. Nevertheless, we consider that the provision of such support without rehabilitation would produce dependency rather than independence. As we explained in Part One of this report, rehabilitation workers can teach skills of mobility, daily living and communication that enable a person with significant sight loss to accomplish many of the tasks that confront all of us every day. Each person will go as far as he or she can towards the goal of maximum independence but, for every person with significant sight loss, there will be challenges which cannot be overcome without the support of a sighted person. For example, rehabilitation can teach how to take basic care of the home, such as bed making, surface cleaning and the like, but sighted support is required to identify some stains, cobwebs in inaccessible places and some cases of structural dilapidation. In short, the interlocking provision of rehabilitation, support and care forms the ground upon which independence and participation will be realised.

4.3.3 In 2015, the government undertook to introduce a Green Paper setting out its proposals for the funding of residential care. It has never been produced, though the present government undertook to do so in its election manifesto of 2019. Whatever solution is proposed for the funding of residential care, the Green Paper will provide an opportunity to revisit the question of the relationship between short- and long-term care. We consider that short-term care should be provided on a basis that guarantees universal access to rehabilitation and thus reduces the cost of residential care.

4.3.4 NFB should, then, campaign for early introduction of the long promised Green Paper and, in accordance with the evidence presented int Parts Two and Three of this report, make the following recommendations:

RECOMMENDATIONS

1 The legislative enactment of a right to independence and participation.

2 A universal offer of rehabilitation for all newly blind and partially-sighted people.

3 Rehabilitation to come before a full community care assessment and be offered regardless of an individual's eligibility for long-term care.

4 Rehabilitation to be available for as long as it is needed.

5 Social care eligibility criteria that properly recognise the unique barriers to independent living that people living with sight loss face.

6 Any agreed vision rehabilitation support must start within twelve weeks of the person's initial contact with the local authority.

7 Sufficient funding to support the provision of rehabilitation, calculated by reference to the population of each local authority.

8 A fully-structured system for collection of relevant information to enable the monitoring of the implementation of rehabilitation-related aspects of the CRPD.

9 Initiatives to collaborate with other relevant disability organisations to ensure that rehabilitation-related concerns are included in future shadow reports to the CRPD Committee.

10 Effective remedies for breach of relevant CRPD requirements, either for individuals or groups and the recognition of central government's accountability for UK compliance with the CRPD.

## 4.4 Campaigning for rehabilitation in the time of coronavirus

4.4.1 The present pandemic, it may be thought, is not a favourable time to launch such a campaign. The attention of national and international authorities is focused on the crisis and the media is unlikely to be receptive.

4.4.2 Against this, NFB should recognise that the pandemic has focused attention, in Britain and world-wide, on the fragility of provision for public health and social care. In particular, the vulnerability of people in residential care has reinforced the argument that provision of rehabilitation and other measures of short-term care reduce the demand for residential care.

4.4.3 It should also be observed that the pandemic is helping to focus attention on the wider need for universal services. There is growing interest in Parliament on the question of universal basic income. Moreover, a significant literature is emerging in support of universal services as a response to recent retrenchment of welfare in Europe and elsewhere (Coote, Wahl). NFB may therefore be confident that the case for universal vision rehabilitation will not fall on deaf ears.

4.4.4 This being so, it would be timely for NFB to begin preparations for launching its campaign for a national rehabilitation framework. It should start by adopting a deadline for the return of comments on this final draft, no later than 31 December 2020. The report could then be presented, after consideration by the EC, to the Annual Delegate Conference in 2021.

# APPENDIX: Support for sight loss and the mixed economy of welfare.

1 The historical review set out in the Campaign Guide, ‘Support for Sight Loss’, will inevitably raise the question of NFB's stance towards the devolution of responsibility for sight loss care and support services from SSDs to local voluntary agencies. This appendix examines two local authority areas as test cases and concludes that they do not yet provide evidence to support any rejection of a mixed economy of welfare.

2 As shown in Finlayson,pp. 287–400, the decades since 1980 have seen the reinvigoration across Britain of voluntary action. In respect of people with sight loss, both the City of Coventry and the neighbouring shire county of Warwickshire have participated in this trend. How far has this gone to strengthen care and support in the sight loss sector? The evidence gathered by NFB Coventry may be summarised as follows:-

3 In 2010 Coventry Resource Centre for the Blind (CRCB) took over responsibility from an older, failing charity. Funding was raised by public appeal to purchase and equip a modern resource centre. Here a range of services is delivered, aimed at supporting people with sight loss to live independently and participate in the community. Training is offered in independent living skills such as cookery and use of computers. A range of cultural and leisure activities is also in place – such as art and craft, gardening and recreational outings. The charity also supports people with sight loss in the often arduous task of claiming welfare benefits. A notable feature of the charity is the input to its governance made by far-seeing people with sight loss, such as the current Chair of its governing body. Not surprisingly, perhaps, this innovating charity won the coveted Queen's Award for Voluntary Service in 2018.

4 Warwickshire has seen a comparable reinvigoration of the voluntary sector. In 2014, the name of Warwickshire Association for the Blind was changed to Warwickshire Vision Support, to reflect the wider reach of modern service delivery from blindness to sight loss. The charity, in the words of its CEO, 'endeavours to offer a holistic approach to sight loss by engaging with the patients at the four eye clinics in Warwickshire’. To this end it employs 2 Eye Clinic Liaison Officers (ECLOs). These inform patients of the charity's vision rehabilitation and care support services.

5 As disclosed on its website, the care support services include a Home Visitor Service which helps 100 people to maintain their 'independence.' The charity has formed Advocacy Groups which 'adopt and develop their own campaigns according to their own local priorities’. There are 4 Vision Support Centres at locations throughout the County which provide 'advice and information, equipment and exhibitions social support and access to all our services'. There are, in addition, 'Pop Up' Support Centres which reach out to the more remote communities in a partly rural county. An Interactive Technology Service offers training in the use of smart phones and tablets. A Super Saver Service, paid for by the Lottery Fund, provides advice on access to social security benefits, consumer information such as best available deal for energy, etc. Finally, WVS supports fourteen clubs and groups which offer 'a wide range of activities and events.'

6 In addition to these support services, WVS Rehabilitation Service delivers training in mobility and independent living skills to registered blind and partially-sighted people, as well as people with significant, but non-registrable sight loss.

7 These models of care and rehabilitation services in Coventry and Warwickshire exhibit interesting differences and similarities. The main difference is in responsibility for vision rehabilitation. In Coventry, it is retained by the SSD, with the voluntary agency, CRCB, concentrating on other care and support services. In Warwickshire, it has been devolved by the SSD to the voluntary agency of WVS. As noted above, WVS claims that this arrangement offers a seamless pathway from diagnosis, through vision rehabilitation to care in the community. CRBC by contrast has no desire to play any role as contracted agent of the City Council. Rather it expresses wariness of dependence on grants from the statutory sector on the grounds that they are subject to sudden withdrawal if and when political exigencies change.

8 The Campaign Guide was not the place to attempt a final evaluation of these models. Nevertheless, it must be noted that both at present fall short of full compliance with the duties laid on local authorities by the Care Act 2014.

9 According to official statistics, these two local authorities have closely similar numbers of people registered as blind – 1125 in Coventry, 1060 in Warwickshire. However, the number of people with significant sight loss is (as we have already noted in the national context) far greater. RNIB estimates suggest that the true number of people with significant sight loss in Coventry and Warwickshire exceeds the number of registered blind people by a factor at least as large as three, perhaps even six.

10 It is against these revised estimates that the scale of provision in Coventry and in Warwickshire should be evaluated. Coventry SSD claims that its vision rehabilitation service effectively reaches all 1125 people registered as blind. WVS claims that its vision rehabilitation service received 804 referrals in 2018-19 (WVS Annual Report).

11 Though not directly comparable, these figures strongly indicate that both models are failing to deliver a rehabilitation plan for all who may be in need of one, as the Care Act requires. They also suggest that, if the model of a mixed economy of welfare were to be abandoned, it is highly unlikely that voluntary agencies would be able to meet the full scale of need at any foreseeable time in the future. If funding were to become dependent wholly on charitable giving, there can be little doubt that the postcode lottery would intensified across the UK. If, as in the Warwickshire case, some element of public funding were to remain, there would be no guarantee that the voluntary agency would be able to exert effective pressure to increase it to meet the demonstrable scale of need revealed in the Campaign Guide.

12 There is no need to resist the present plans of either CRCB or WVS for expanding their activities. What NFB should resist is any attempt to make public expenditure savings by moving away from the model of a mixed economy of welfare. Charitable activity alone will never abolish the postcode lottery.

# BIBLIOGRAPHY

Campbell, J. and Oliver, M., Disability Politics: Understanding Our Past, Changing our Future (London, Routledge, 1986).

Collingbourne, T., The Care Act 2014: a Missed Opportunity, The Independent Living Debate, Vol. 20, No. 23 (2014[).](http://www.theindependentlivingdebate.worldpress.com) <http://www.theindependentlivingdebate.worldpress.com>

Coote, A. and Percy, A., The Case for Universal Basic Services (London, Polity, 2020).

Finlayson, G., Citizen, State, and Social Welfare in Britain, 1830-1990 (Oxford, OUP, 1994).

Goffman, I., Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (London, Penguin Books, 1991, first pub. 1961).

Department of Health, Independence, Well-Being and Choice: Our Vision for the Future of Social Care for Adults in England (London, HMSO, 2005).

Department of Health, Our Health, Our Care, Our Say: a New Direction for Community Services (London, HMSO, 2006).

Department of Health and Social Care, Caring for Our Future, Reforming Care and Support (London, HMSO, 2012).

Low, R., The Welfare State in Britain since 1945 (London, Macmillan, 1993).

National Audit Office, Adult Social Care at a Glance (London, 2018).

Phillips, G., The Blind in British Society: Charity, State and Community, c. 1780-1930 (Aldershot, Ashgate, 2004).

Pugh, M., State and Society: a Social and Political History of Britain since 1870 (London, Bloomsbury, 1994, 5th edn. 2017).

Reid, F., ‘The Panopticon: Towards an Intimate History of Special Schools for the Blind’, Ch. 9 in Hutchison, I., Atherton, M., Virdi, J. (eds), Disability and the Victorians: Attitudes, Interventions, Legacies (Manchester, Manchester UP, 2020).

RNIB, Facing Blindness Alone: What Government Needs to Do Now to Stop the Isolation of Blind People available at <https://www.rnib.org.uk/sites/default/files/Facing%20blindness%20alone%20Campaign%20report.doc>

RNIB, Key Information and statistics: See Differently at <https://www.rnib.org.uk/professionals/knowledge-and-research-hub/key-information-and-statistics>).

RNIB, See, Plan, Provide available at <https://www.rnib.org.uk/sites/default/files/See%2C%20plan%20and%20provide%20report_clearprintfinal.docx>

Seebohm, F., Report of the Committee on Local Authority and Allied Personal Social Services (London, HMSO, Cmnd 3703, 1968).

Sloan, B., ‘Covid-19 and the Care Act 2014’ in Tidball, M. et al, An Affront to Dignity, Inclusion and Equality: Coronavirus and the Impact of Law, Policy, Practice and Access to Services on People with Disabilities in the United Kingdom (Oxford University Disability Law and Policy Project and the Bonavero Institute of Human Rights, July 2020) available at <https://www.law.ox.ac.uk/news/2020-07-02-affront-dignity-inclusion-and-equality-coronavirus-and-impact-law-policy-practice>

Townsend, P. (ed), The fifth social service: a critical analysis of the Seebohm proposals (London, The Fabian Society, 1970).

UK Government, The United Kingdom Government Response to the Report by the United Nations Committee on the Rights of Persons with Disabilities under Article 6 of the Optional Protocol to the Convention (November 2016), available at <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2f17%2fR.3&Lang=en>

UN Committee on the Rights of Persons with Disabilities (2016), Inquiry Concerning the United Kingdom of Great Britain and Northern Ireland Carried out by the Committee Under Article 6 of the Optional Protocol to the Convention: Report of the Committee (November 2016).

UN Committee on the Rights of Persons with Disabilities (2017), Concluding Observations on the Initial Report of the United Kingdom of Great Britain and Northern Ireland CRPD/C/GBR/CO/1 (3 October 2017).

Wanless, D., Securing Good Care for Older People: Taking a Long-Term View, (The King's Fund, 2006, <http://www.kingsfund.org.uk>).

Wahl, A., The Rise and Fall of the Welfare State, tr. Irons, J., (London, Pluto, 2011).

Webb, A. and Wistow, G., Social Work, Social Care and Social Planning: the Personal Social Service since Seebohm (London, Longman, 1987).

Wilson, K., Ruch, G., Lymbery, M., Cooper, A., Social Work: an Introduction to Contemporary Practice (Harlow, Longman, first pub. 2008, 2nd edn 2008).

Younghusband, E.L., Report of the Working Party on Social Workers in the local Authority Health and Welfare Services (London, HMSO, 1959).