All Party Parliamentary
Local Government Group

CARE NOW AND FOR THE FUTURE

AN INQUIRY INTO ADULT SOCIAL CARE

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For many of my constituents one of their biggest worries is how they are going to be looked after in their old age. They worry about whether they will need care, whether it will meet their requirements and whether they'll be able to afford it.

We should celebrate the fact that more and more of us are living longer, but it does mean that these sorts of worries about care will become more pressing.

Government recognises this problem and following the report of the Dilnot Commission last year we now have cross-party talks on funding, a White Paper on social care and a draft bill on the way.

As the All Party Parliamentary Group on Local Government, however, we are very conscious that while this is an important national issue, perhaps the most important of our time, it is at local level that it really affects people and it is local government that plays the most important role in the commissioning and management of care services for older people.

We wanted to find out, through our Inquiry, what needed to be done and, specifically, what local government could do, to help build a social care system fit for the future.

We received evidence from experts and representatives of over 80 organisations, including councils, care providers and carers groups and we are very grateful to all those who helped us in our deliberations, the results of which are set out in this report.

We found, as we expected, that the current system faces significant pressures, especially around funding, but we also concluded that the most important reform for a future system was to completely re-orientate it to focus on preventative services and we have made some suggestions as to the practical steps necessary to achieve this. This will save money and deliver better results for older people.

The role of local government is also changing fast and we found evidence that councils around the country were already blazing a trail towards a more integrated, more effective system. The challenge now is to spread this good practice.

We hope and believe that this report will be useful for national policy makers, but most of all we hope it will provide practical inspiration to local authorities across the country about the things they can do immediately to help ensure we deliver quality care to our elderly people now and in years to come.

Heather Wheeler MP
Chair, All Party Parliamentary Group on Local Government

There is much to celebrate about the opportunity to live longer. The idea that many people will routinely become centenarians would have seemed fantastical to past generations. Not only can we hope to enjoy a longer life, but also one that is potentially more full. The ideal of course is that we are able to enjoy good health and be active throughout this long and fulfilled life, which one day ends quickly and peacefully. The reality though is that in our later years most of us will have care needs of one form of another, and at the end of our life those needs are likely to become more critical. This should not be something to fear, but rather an accepted and planned for part of the opportunity to grow old.

The government, central and local, has a responsibility to do some of the planning. But where in the past the government was relied upon to provide for people's care needs, in the future we need more of a partnership with individuals, families, communities and the state. This report considers both the action needed from central and local government, particularly the reform of the health and social care system, and how a new partnership can be shaped for the funding and delivery of care.

We are delighted to have the opportunity, as advisers to the Inquiry, to work with a wide range of Parliamentarians and many interested organisations in the public, private and voluntary sector, to think about the future of care. For our part, the LGiU is keen to support those who wish to achieve some consensus on the way forward. The MPs and Peers who formed the Inquiry panel, led by Heather Wheeler, were generous with their time and expertise. More than this though, they were generous in spirit, striving to overcome different views of the past history and present condition of the care system, in order to reach a shared perspective on the way forward. The cross-party support for this report makes it a unique contribution to the debate.

There are many local government bodies, LGiU included, that have contributed consistently to reviews, consultations and forums debating the future of social care. What is new about this Inquiry is the quality of interactions between Parliamentarians and those who lead local councils and local service provision. We have looked at the general position of local government, but more than this we have focused on different experiences around the country, of innovation and of the challenges ahead. We are grateful, for example, to those authorities who opened up their books and gave us real insight into the funding of care, and the future prospects.

All this evidence shines a light on a crucial factor: the future of social care is, and should be, shaped in part by local circumstances and aspirations. Communities, service users, volunteers, carers, businesses, councillors and local public service providers, all have a role and should all have a say. We hope this report inspires many conversations, and even more action.

Andy Sawford
Chief Executive
Local Government Information Unit

Executive summary

Local authorities have the primary responsibility to make sure that the care needs of older people are met now and in the future. In our Inquiry into the social care system we have heard evidence from over 80 organisations including local authorities, care providers and user groups.

As expected this points to an urgent and growing social care funding problem. The government is very aware of this and a funding White Paper is due to be published. We have commented on funding reform in the long term, giving particular consideration to the proposals made by the Dilnot Commission. However, we have chosen as our focus the changes that we believe can be made now to improve the care system and meet current funding challenges.

We believe that the key to improving care now and for the future is the systemic re-orientation of the health and social care system towards prevention. This will take out costs both for individuals and the public purse, lessen demand for care and provide better outcomes for older people.

We have heard evidence of innovative and successful approaches to care that point the way for local authorities and the NHS. The best local partnerships are helping to manage the demand for and cost of care by: enabling citizens to lead independent lives through investment in preventative and reabling services; helping people to be financially independent by connecting them with appropriate financial advice; and acting as market-shapers for care services.

We believe that a step change is needed in the scale and pace of integration and alignment in the health and social care system. The introduction of new Health and Wellbeing Boards can be a powerful driver of these changes and we have made recommendations on how this can be supported and strengthened.

Similarly, we believe that the 'Community Budgets' approach, already being championed by the government in respect of family intervention, will be key to bringing health and social care together.

On the long-term funding changes, the evidence we heard was broadly supportive of the Dilnot Commission's proposals. Everyone agrees that we need to get more money into the system and it is clear that the taxpayer cannot afford to foot the bill. The majority of people already fund their own care and this will continue in the future. What we must do is to help people plan for their future care needs and ensure that, where people are asked to contribute, that the system is fair and transparent.

Clarity around funding will allow both individuals and public agencies to plan for the future and will allow the development of a competitive market in financial and other products that make use of people's assets to enable them to provide for their care costs. We also urge local authorities to gear up to play an increasingly important role in referring people towards advice and guidance about the options available to them.

Finally, we have grappled with evidence of the current funding gap which local authorities estimate at 4.4% per annum, equivalent to £634 million in the next two years and rising thereafter. The government

has already re-directed resources from NHS budgets to social care budgets to help meet the short term funding gap. We make recommendations on the accountability for how these resources are being used, and make the case for a doubling of these resources.

We have made four key recommendations:

Recommendation 1: Local government and the NHS must integrate services and budgets to change the focus of social care services and spending towards prevention. There is already substantial progress towards this goal – as our Inquiry shows – but a step change is needed. To help drive this change we recommend that Community Budgets, which are currently being piloted by the government, are implemented across all local authority areas with a focus on preventative health services.

Recommendation 2: We have heard how Health and Wellbeing Boards are already making an impact and have great potential. To realise this, the Boards need powers to influence the NHS Commissioning Boards' plans, and the right to challenge those plans if they are not sufficiently in keeping with the joint health and wellbeing strategy. The NHS Commissioning Board should have a duty to cooperate with the Health and Wellbeing Board in the exercise of its functions and specifically in relation to the promotion of integration and collaborative working. We recommend that the NHS and local authorities be required to make an annual statement that accounts for all NHS and adult social care expenditure so that members of Health and Wellbeing Boards can scrutinise and challenge the choices made. This information should also be made publicly available.

Recommendation 3: To close the funding gap that our evidence suggests is around 4.4% per year, equivalent to £634 million, we recommend that the government divert additional resources from NHS budgets to preventative care. In the current year £622 million of NHS money has been invested in social care. We recommend that this is doubled in 2012/13 and 2014/15 to the end of the CSR period, using funds from NHS underspends (currently £1.5 billion) ahead of savings accruing.

Recommendation 4: Local authorities across the country should as a matter of urgency emulate the best practice featured in this report to help people stay independent for longer; to manage and stimulate a market of care provision; and to ensure that all citizens, not just those funded by the council, receive timely and appropriate advice about their care options and about how to manage their finances effectively to meet the costs of their care.

Taken together, we hope that our report and recommendations, based in evidence and presented on a cross party basis, will help the government, local authorities, the NHS and all those they work with to help improve care now and for the future.

“Everyone agrees that we need to get more money into the system. It is also clear, however, that the taxpayer cannot afford to foot the bill alone.”

1 Introduction

How do you want to spend your old age?

We would all answer this question differently but we can imagine that certain common features might emerge. Many of us would prefer to spend our final years in our own homes, but not to be completely isolated. If we have to go into residential care, we want that setting to be comfortable, safe and stimulating. We would prefer not to be sick, or vulnerable or needy, but if we are we would like to be cared for and cared for in ways that are responsive to our needs. In sum we want dignity, autonomy and security in our old age.

For policy makers a parallel set of questions emerges. How much are we willing to spend on care for older people? How should this spending be divided between acute and social care? What contribution do we expect or need from people and their families? How do we construct a system that delivers integrated care effectively to people who need it at the appropriate time and place?

The need to find answers to these questions is getting more urgent. We know, for example, that life expectancy in the developed world is increasing at a rate of two years per decade. The number of people over the age of a hundred will increase a hundredfold to one million over the next 60 years. People now live with chronic illness for an average of eight years at the end of their lives.[1] How we care for this growing elderly population is the most pressing public policy problem of our time. It is, of course, a problem for central government and it is in these terms that it is usually discussed. But it is also, perhaps most of all, an issue for local government.

It is overwhelmingly local government that funds, commissions and in some cases still provides social care. It is local government that picks up the pieces when things go wrong and it is local government that will play the biggest role in making sure that we get the care we need.

This is why, over recent months and with the support of the LGiU, the All Party Parliamentary Group for Local Government (APPG) has held an inquiry on the future of adult social care. We received evidence from over 80 organisations including local authorities, care providers and user groups. As expected this points to an urgent and growing funding problem. The government, which is very aware of this issue, commissioned the Dilnot Report last year and a funding White Paper is due soon. The evidence we heard was broadly supportive of the Dilnot Commission's proposals.

Everyone agrees that we need to get more money into the system. It is also clear, however, that the taxpayer cannot afford to foot the bill alone. The majority of people already fund their own care and this will continue in the future. What we must do is to help people plan for their future care needs and ensure that, where people are asked to contribute to the cost of this, that the system is fair and transparent.

We recommend that local authorities gear up to play an increasingly important role in referring people towards advice and

1 Brown, G (2007) *The Living End: The New Sciences of Death, Ageing and Immortality*

guidance about the options available to them. The Group also believes that clarity around funding will allow both individuals and public agencies to plan for the future and will allow the development of a competitive market in financial and other products that make use of people's assets to enable them to provide for their care costs.

We also considered how costs in the system can be reduced by re-orienting health and social care towards prevention. This will take out costs from the system both for individuals and the public purse, lessen demand for care and provide better outcomes for older people. However, this will require real integration across the public sector and for this to happen at a greater scale than it currently does will need major structural and budgetary reform. The introduction of new Health and Wellbeing Boards can be a powerful driver of change and we will make recommendations on the role they can play. Similarly, we believe that the 'Community Budgets' approach, already being championed by the government in respect of family intervention, will be key to bringing health and social care together.

Finally, although it was not the key focus of this Inquiry, we will consider some of the ways in which we might reform funding of the social care system, including the recommendations of the Dilnot Commission that are currently under review by the government. We argue, however, that the crucial debate about funding will be academic unless it is accompanied by serious reform to build a new type of care system that better serves the needs of the elderly and vulnerable.

The evidence reviewed in this report offers a powerful description of a system with significant care funding gaps that is rapidly approaching a critical point. However, it also offers a picture of the sort of best practice and innovation that may lead to a system fit for the future. The group found that some local authorities around the country were already modelling a new role focused on: enabling citizens to lead independent lives through preventative and re-enabling services; helping people to be financially independent by connecting them with appropriate financial advice; and acting as market-shapers for care services. These new approaches were already saving money and creating better outcomes for older people and should be emulated immediately.

Reforming social care funding and delivery will not be easy but it must be done. The Group hopes that, by working in a cross party way and by focusing on the critical role of local government, our report will add ideas and urgency to the current debate as well as helping to achieve a political consensus on the action that is needed now and in the future. We hope that the report will inform the adult social care system of the future and chart a road map from where we are now to where we need to be if we are all to be able to confidently answer those questions about the sort of old age we want.

2 How did we get here? The policy context

There have been successive attempts to reform the adult social care system over four different governments: from the 1997 Joseph Rowntree Foundation inquiry, *Meeting the Costs of Continuing Care,* through to the Dilnot Commission. [2] [3]

The Royal Commission on Long Term Care, established just six months after Tony Blair's first term, reported in 1999 and made a series of recommendations on care reform, including paying for personal care through general taxation according to need and establishing a National Care Commission.[4]

This was followed by a report by Sir Derek Wanless, *Securing our Future Health,* which called for a full review of adult social care.[5] Wanless subsequently recommended that funding be delivered through a partnership approach with contributions from both the state and the individual.[6] In 2010 The Personal Care at Home Act was passed by the then Labour government but attempts at achieving a political consensus broke down before the General Election and the incoming government did not implement the Act.

Are there factors now that could deliver reform, where previous attempts have not? Demographic change, with an ageing population, fewer working age adults and decreasing capacity for family to support, though not a sudden phenomenon, has become a reality to policy makers and the public alike. The risks associated with complex financial models have also become more stark with recent well publicised examples of arrangements going wrong like the collapse of Southern Cross. There is increasing concern over quality and safeguarding that may not be new, but is now, thankfully, higher up the public agenda.

In 2011, the Dilnot Commission reported on its recommendations for the reform of social care funding.[7] The government will respond to these proposals in a White Paper, due to be published in July 2012, and is widely expected to endorse the the principles of Dilnot while deferring a decision on the detail of how to fund them.

Social care market

Perhaps the biggest factor in shaping the current context has been the evolution of the social care market which is now one of the most developed markets in the public sector. This began with the government's commitment in the 1980s to a 'mixed economy of care' and the market saw a rapid expansion from the early 1990s. The 1990 National Health Service and Community Care Act began the process of radically changing the role of social service departments from providers to becoming brokers to a range of care and support providers. In 1990 the independent sector provided only 2% of state-funded home care; it now provides more than 80%.

2 Joseph Rowntree Foundation (1996) *Meeting the costs of continuing care*
3 Commission on Funding of Care and Support (2011) *Fairer funding for all*
4 Royal Commission on Long Term Care (1999) *Long-term care – rights and responsibilities*
5 Department of Health (2002) *Securing our future health: taking a long-term view*
6 The King's Fund (2005) *Securing good care for older people*
7 Commission on Funding of Care and Support (2011) *Fairer funding for all*

The 1990 Act also developed the concept of individualised packages of care. There were related attempts to strengthen commissioning capacity and it also saw the emergence of joint commissioning (which took several different forms and has never been consistently successful). Joint-working and commissioning seemed to stall after the first enthusiasm but was given a new lease of life with the emergence of Joint Strategic Needs Assessments (JSNAs) and a new emphasis on outcome-based commissioning.

Despite the existence of a market in social care over two decades or more there are questions about the maturity of that market. Has the current market the ability to deliver an appropriate balance between competition and collaboration? Does it deliver efficiencies and quality. Is it sufficiently diverse to be able to respond to personalisation? Who are the current providers? It is a very diverse market. In terms of care homes, almost 90% of nearly 9,000 residential care providers own only one or two homes.

The largest 10 providers, however, account for 10% of the market (by homes). As David Behan, director general of social care, local government and health partnerships at Department of Health, has argued:

"At the other end of the spectrum, there are large organisations spanning the country, backed by private equity and corporate investors. The way this market has developed has also led to the large, and growing, numbers of alternative provider models. Social enterprises, voluntary bodies, mutuals, co-operatives, microenterprises and personal assistants, all offer people a wide range of options".[8]

It remains unclear, however, how this market will develop over the next decade. Will personalisation lead to an increased fragmentation or will we see a drive towards economies of scale and ever larger providers? As we shall argue later in this report, the shaping and management of this market will be an increasingly important part of the local authority role.

Choice and control agenda

The growth of the disability movement, particularly from the 1970s onwards, challenged the traditional balance of power in social care and saw the development of the social model of disability and the independent living movement. The mid-1990s saw the introduction of direct payments. A series of government publications advocated 'self-directed' support.

The White Paper, *Our Health, Our Care, Our Say* in 2006 was followed by *Putting People First* in 2007 and the 2010 *Capable Communities and Active Citizens* document, supported by the Think Local, Act Personal partnership.[9] The personalisation agenda developed from the recognition that service users needed to be involved much more directly in their own care and that doing so would result in more targeted and cost effective services. The coalition government built on the previous government's introduction of personal budgets with the commitment to a personal budget being available for everyone eligible for ongoing social care by 2013.

Wider policy agenda

The evolution of social care to a largely marketised service, though in advance of

8 http://www.guardian.co.uk/social-care-network (2012) *Social care provision: what can we learn from our diverse market?* (2012)

9 Department of Health (2006) *Our health, our care, our say: a new direction for community services*

other service areas, reflects the wider policy agenda over the last two decades from public service management theory through to the Open Public Services White Paper and the Health and Social Care Act.[10] This government is committed to widening 'choice and control' and increasing the diversity of providers across public services.

There has also been the related focus on outcomes and outcome based commissioning and outcome-based assessments in adult social care, though as we shall see, the theory is arguably more prominent than the practice.

Alongside outcome-based commissioning, there has been the development and promotion of co-production, where service users give their own time and skills to run aspects of their own care with professionals. Many councils have been at the forefront of developing these new forms of delivery, particularly through the use of personal budgets, in addition to co-commissioning and co-designing services with users.

10 HM Government (2011) Open Public Services White Paper

“The funding system needs to support the principles about what a good care system should offer to the people. So it is not just about what are we paying and how do we pay for it. But what is it that we are paying for? How do you get good care? And how the funding system delivers that good care.”

Shaun Gallagher, Director of Social Care Policy, Department of Health

3 What do we know about the problem?

The APPG was concerned to get a sense of the extent to which there were real and measurable problems in the delivery and funding of adult social care either now or in the future. Many analysts believe that there is a substantial funding gap in adult social care which the King's Fund estimates at £1.2 billion by 2014.[11]

The Rt Hon Paul Burstow MP, Minister for Social Care, told the House of Commons Health Select Committee that the government had moved £7.2 billion into social care from health and expected councils to find 3% savings through efficiencies.

He said: "There is no gap in the current spending review period on the basis of the money that we are putting in plus efficiency gains through local authorities redesigning services."[12]

Local authorities and others giving evidence to this Inquiry were asked whether they believed there was a care funding gap in their locality and, if so, what their estimate of its scale was. They were also asked about changes in resource and demand and how far they were able to make savings through efficiencies now and in the future.

This data makes an important new contribution to the debate because it is not based on universal calculations or national projections but built from the ground up from the real budgets of the organisations who are actually spending this money and delivering these services.

1. Rising demand

All authorities predicted a rise in demand as a result of demographic pressures. Based on these estimates, the LGiU has calculated that increases in the number of people with care and support needs are resulting in a 4.1% per year increase in spending. This increase in cost is compounded by a reduction in overall funding for local government (28% on average over the four years of the last spending review period).

Our calculations of increased demand are based on projections of demographic change prepared by individual authorities. Derbyshire County Council, for instance, has used a model based on Wanless methodology, formalised by Planning4care, which was recommended by the Audit Commission as the basis for planning for future social care needs. Based on this model, the authority estimates that overall care needs are rising by around £16 million per year. Derbyshire County Council points out that this calculation is complex as it is affected by the contribution of carers, the level of self-funding and the effectiveness of their prevention strategies as well as the application of eligibility criteria.

2. Inflation

Several respondents argued that increasing care costs were a significant factor. London Councils noted that inflation in care costs has a pronounced impact on higher-cost areas of the UK. The Association of Directors of Adult Social Services (ADASS)

11 The King's Fund (2012) *Briefing: the future of adult social care*

12 Health Select Committee (2012) *Fourteenth report of the session 2010-2012: social care*

budget survey 2012 found that providers of residential care for older people and people with physical disabilities received an average increase of 2%.[13] Providers, however, noted that local authority fee increases vary significantly. Bupa expects that local authority fee increases in 2012-13 will "repeat what we have seen in previous years and vary hugely across the country. Some local councils have, commendably, recognised the problems facing providers. But others are continuing to negotiate below inflation increases and fees, on average, have been decreasing for the last four years".

Bupa argues that this is unsustainable and could create real difficulties in particular for smaller providers, who make up the majority of the market, as they are less able to realise economies of scale.

3. Growing complexity

A large number of authorities expressed concern about the increasing complexity of need. Dementia was a particular area for concern. The Alzheimer's Society points out that the diagnosis rate for people with dementia has increased by 2% in a year.

Some authorities were particularly concerned. Halton Council projects that the number of people with dementia in Halton is forecast to increase by 55% between 2010 and 2025. Increased complexity of need also has a regional character. Bristol City Council points out that the South West has the second highest prevalence of learning disability and the greatest prevalence of people with moderate or serious personal care disabilities in the country.

Many of the respondents expressed concern about increased costs associated with more complex needs. The Alzheimer's Society projects that the cost of dementia will rise from £23 billion a year to £27 billion by 2018.

4. Reduction in resources

The increase in demand outlined above is coupled with a reduction in resources over the near and medium term future. The Local Government Association (LGA) estimates that local government in England will see a decline in its funding for services other than schools and children's services over the life of the Spending Review.[14] It puts this at about 16% in real terms. The LGA argues that this is the backdrop against which questions about the adequacy of funding for social care have to be answered.

The 2012 ADASS budget survey has found that adult social care would provide a contribution to savings in 2012/13 of £890 million. This represents 6.8% of the 2012-13 adult social care budget before savings.[15]

Evidence submitted to this Inquiry indicates that adult services departments are planning for a reduction in budgets to continue at a rate of 4.4% per year up to 2015. The divergence between the ADASS figure for 2012-13 and the forecasts submitted to the Inquiry can be explained by the fact that budget cuts fell more heavily in the early years of the current spending review period.

Some concern was expressed about the local variation in these spending reductions. London councils argued that the changes to the Relative Needs Formulae in 2006 have worsened the situation for London as this now completely fails to recognise the unique levels of need in London resulting in an unfair distribution of funding away from London. There are still further complexities

13 Association of Directors of Adult Services (2012) *Budget survey 2012*
14 Health Select Committee (2010) *Written evidence: public expenditure*
15 Association of Directors of Adult Services (2012) *Budget survey 2012*

within this. London Borough of Havering said that the average per head funding for London was £480 whereas Havering received only £263.

Concern was also expressed about how this reduction was shared across the public sector. One respondent noted that, although over the past 15 years real spending on adult social care has increased by 70%, the Dilnot Commission suggests that over the past four years demand has still outstripped social care spending by around 9%. In contrast, real spending in the NHS has risen by almost 110% over the same period.[16]

5. The scale of the funding gap

Estimates submitted to the Inquiry by local authorities suggest that a divergence of demand and resources is occurring as a result of reduction in resources and increases in demand outlined above. As we have seen, the LGiU has calculated that increases in the number of people with care and support needs is resulting in a 4.1% per year increase in spending. We have also noted that this increase in cost is compounded by a reduction in funding for local government. The figures provided by local authorities to the APPG suggest that this is resulting in a reduction to adult services budgets of 4.4% a year.

This means that an average adult services department faces a theoretical budget gap of 8.5%. It must be emphasised, however, that local authorities are taking action to mitigate this divergence between demand and resources.

Evidence submitted to the Inquiry indicates that local authorities are deflecting an average annual cost increase of 4.1% as a result of investment in preventative services and service redesign. This investment is helping to mitigate the cost of rising demand and budget reductions. This is important as savings as a result of investment in these services can maintain or in some cases improve outcomes for service users. Surrey County Council, for instance, states that cost avoidance through preventative services is a significant part of the council's medium-term financial plan. One aspect of this savings programme is a significant investment in telecare and telehealth to save £15 million per year by 2016-17 through paying less for support packages.

Taken together, we see that savings of 4.1% against a theoretical budget gap of 8.5% leaves us with an overall budget gap of 4.4% per annum. Authorities are in a position where savings from prevention and service redesign are adequate to keep pace with either rising demand, or budget cuts, but not both.

As Warwickshire County Council argues: "Modernisation and transformation of social care services is progressing at a pace and is delivering savings of well over 5% per year, but those savings will be used up in meeting savings targets driven by the current reductions in public funding. Even if modernisation savings were available to cover demographic pressures, these savings will be exhausted within a few years while demographic pressures will continue to grow for decades to come."

Estimates of the size of the funding gap are likely to be further affected by changes pledged by the government in response to the report by the Law Commission on social care law reform.

As recently as 20 June 2012, the Minister for Social Care told Parliament: "We will shortly set out a comprehensive overhaul of social care law in this country, placing

16 Commission on Funding of Care and Support (2011) *Fairer funding for all*

people's wellbeing at the heart of decision making and focusing on goals that matter to individuals. We will build on the excellent report by the Law Commission on social care law reform to ensure that we have a legal framework that supports a much more personalised approach".[17]

In addition the government has pledged to implement work force reforms. We recommend that the government works with local authorities to model the financial implications of these changes.

6. The urgency of the problem

The divergence of demand and resources poses a significant challenge to local government. Nottinghamshire County Council calculates, based on the figures in the Dilnot Commission's report about funding required to meet future demographic needs, that it would need an extra £125 million by 2025 on top of the net budget of £219 million. This would take adult social care spending to around 70% of Nottinghamshire County Council's expenditure.

Similarly, the London Borough of Barnet has undertaken a detailed analysis of the cost pressures arising from children's and adult social care which shows that if the current arrangements continue by 2026 there will be no funding available for any other service apart from children and adult services.

Carers' organisations emphasised that local authorities were not the only provider of care to be affected by this increase in demand and reduction in resource. Carers UK project that in the next 20 years the supply of care by families is likely to grow by 13% while demand will increase by 55%.

It is estimated that by 2017 we will reach a 'tipping point' where demand will outstrip what families are able to provide. This would of course have a significant impact on local authorities. In their submission, the London Borough of Tower Hamlets identified its reliance on informal care as a risk.

Devon County Council cited a study by charity Carers UK and the University of Leeds in 2011 which estimated that carers save the UK £119 billion per year. 2010 population estimates are that 1.7% of the UK's population over the age of 65 live in the Devon County Council area. As a crude proxy, this would suggest that carers collectively save health and social care authorities in Devon £2.03 billion a year.

17 Hansard (2012) *House of Commons Debates 20 June 2012*

Key findings/recommendations

We believe that the evidence received by this Inquiry demonstrates beyond doubt that a funding gap exists now and will grow unless there are major reforms both of the system and the way it is funded.

Local authorities are making savings of 4.1% a year through investing in preventative services and service redesign: a greater saving than the 3% the government expects from them. Even with this however, rising demand and shrinking resources, means that a funding gap of 4.4% per annum remains. Equivalent to £634 million.

We therefore believe that it is imperative that we find new ways to lever resource into the care system.

Against a backdrop of cross party talks, the government is considering its response to the Dilnot Commission's recommendations on social care funding. A White Paper and progress report on funding are scheduled for July 2012 and are widely expected to endorse the principle of Dilnot's proposals while deferring a decision on the detail of how to fund them. But if we are to take a decisive step forward in the consideration of this challenge, we need bold political leadership from all parties to make some tough choices in establishing a new funding settlement for care.

But while the question of long-term funding reform is both vital and urgent, this group believes that there are nonetheless things we can do right now to build on the work local authorities are already doing to save money and deliver better results through preventative work.

In the medium term there are also crucial structural reforms we must undertake to create a more efficient system focused on prevention and the management of demand.

Unless we undertake these reforms then changes to funding will simply involve pouring further resource into a system that is not capable of meeting the challenges we have outlined in this chapter.

As Shaun Gallagher, Director of Social Care Policy at the Department of Health, told the Inquiry: "The funding system needs to support the principles about what a good care system should offer to the people. So it is not just about what are we paying and how do we pay for it. But what is it that we are paying for? How do you get good care? And how the funding system delivers that good care."

Local authorities have a crucial role to play both in the immediate steps we can take and in the longer term shift to a more preventative system and it is on these elements that this Inquiry has therefore chosen to focus.

4 What can we do now? The changing role of local authorities

While much of the detail of a future care system and its funding remains to be decided, we believe that the evidence gathered by this Inquiry reveals the basic shape of that system.

We can see that any system will involve a mixture of state funding at some level and significant contributions from individuals. But however these are combined they will not bring enough resource into the system by themselves and we will therefore need to see a system that is re-designed to become far more integrated and preventative.

This suggests a changing role for local government. As we shall see many of the case studies received by this Inquiry reveal councils already modelling this future role, which we believe will have three core components:

- enabling citizens to lead independent lives through preventative and re-enabling services
- enabling citizens to be financially independent, by connecting them to appropriate advice
- acting as a market-shaper for care services.

1. Enabling citizens to lead independent lives

The evidence reviewed here demonstrates that local authorities clearly recognise the value of intervening early, working with partners in health to build holistic support for older people and supporting individuals to remain in their own homes. The LGiU has argued, in a previous publication, that the scale of the demographic challenge means that local government will increasingly be required to invest in the capacity of individuals and communities to support the needs of the burgeoning number of older people.[18] Liverpool City Council reflected this view in its argument that the future role of local government will be to ensure there is provision to meet demand and a model of care available which promotes independence and builds on existing community assets.

Identification of carers and enhancing support for them is perhaps the most urgent aspect of this changing role. Several respondents indicated that uncertainty about the number and location of carers locally was a significant issue. The Carers Trust Network noted that the Carers Development Worker project at The Princess Royal Trust Worthing and District Carers Liaison Service has consistently increased its numbers of registered and supported carers since 2004 in several GP practices.

Improving carer support is a significant opportunity for local government as carer breakdown can result in admission to adult social care. Hertfordshire County County Council already currently spends approximately £4 million per year specifically on services to support carers.

However, with 17% of admissions to permanent residential care in Hertfordshire involving carer breakdown, the council has

18 LGiU (2010) *People Places Power: how localism and strategic planning can work together*

London Borough of Tower Hamlets: carer support

Carers of people with end-stage heart failure are referred to a care coordinator to provide support. The care coordinator can fast-track access to services across health and social care, and has an emergency fund of up to £250 for equipment that makes the caring role easier. There has been a large reduction in hospital admissions (approximately 28 days fewer in hospital per patient than expected), an increase in people dying at home, and fewer carers needing bereavement services.

Leeds City Council: developing community support

Over the past 16 years, Leeds City Council has supported the establishment of 38 community-based organisations for supporting older people's independence. These are known as Neighbourhood Networks (NN) and, between them, they cover every area in the city.

Currently, they give on-going support to over 17,174 older people with services being delivered with the support of 5,948 volunteers, many of whom are older people themselves. The NNs play a prominent role in the lives of many older people in the city, providing services including support on hospital discharge, dementia cafes, befriending, shopping, gardening, advocacy, luncheon clubs, walking groups, benefits advice, social activities and a wide variety of others.

Over the past year, the council has been moving the organisations away from an annual grant funding formula to the stability of five-year contracts (with an option for a further three years' extension). The contracts are awarded for focus on four agreed priorities: reducing isolation; giving people choice and control over their lives; enhanced wellbeing and healthier life choices; increased participation and involvement of older people in the NNs and the communities in which they live.

The annual cost of the contracts to the NNs amounts to £2 million per year with £1.73 million from the council and £270,000 from NHS Leeds.

concluded that there is scope to significantly delay residential care admissions by investing in helping carers continue to care. It is estimated that additional services for carers could save £3 million over five years.

By providing opportunities for co-production, local authorities can harness the additional resources, skills and expertise that individuals and communities can contribute to the delivery of care services, alongside those delivered by professionals. This may include making opportunities available for co-commissioning, co-design and co-delivery of services. This approach gives service users the opportunity to become actively involved in the delivery of their own care in order to enable them to live independently for longer. Additionally, co-production can support the system of delivering social care

and, in the long term, contribute towards making it more sustainable.

2. Enabling citizens to be financially independent

Almost all respondents to the Inquiry were clear that the partnership model (care being met by a combination of state and personal funding) was, at present, the most politically feasible approach to the future funding of adult social care. There was broad agreement, however, that the current system was not making the most effective use of people's assets.

In their evidence, Partnership Assurance estimated that poor decisions about care funding are resulting in one in four self-funders falling back on state-funded care at an annual cost of up to £1 billion for long-term care, a cost they believed could treble over the next 20 years.

There are a wide range of possible financial solutions for individuals to fund their own care. As the ADASS has argued, these include "savings, deferred payments, equity release, pensions and savings products, immediate care needs annuity products and even keeping the cash under the bed. In a world where holding the trust of people will matter, this range of products, and the development of new offers in these areas, seems to us to offer the best chance of getting care cost protection to the greatest percentage of the population".[19]

The uptake of financial products designed to help with care costs is currently poor. In part, this is due to low awareness. Only 4% of the 40% of people who would benefit from investing in a financial product to fund their care do so. There was broad agreement that local government will need to build on existing good practice in ensuring that the resources of self-funders, who make up an increasing proportion of recipients of care, are supported to make the most effective use of their resources.

Local government will also need to help encourage individuals to make earlier, and more cost-effective, investments in services aimed at supporting independent living and modifications that could help older people remain in their own homes in the longer term.

Helping people remain financially independent has three key aspects.

First, ensuring that older people remain economically active for as long as possible. Bradford City Council has developed a range of tailored support including job clubs for older people. Bristol City Council requires providers to work with employers to prioritise the employment and skills needs of older jobseekers and, through West at Work and the Employment and Skills Board, includes targeting older job-seekers and workers as a priority group.

Second, ensuring that uptake of benefits is maximised. As Sunderland City Council argued, provision of benefits advice plays a vital role in helping to reduce or alleviate poverty, inequality and deprivation levels. The council funds both in-house and contracted advice services to ensure that residents can continue to access the advice and information that they need in the manner that is most appropriate for them to do so. In the year to February 2012, 2,778 people aged 60-65, 2,656 people aged 65-80 and 2,246 people over 80 were provided with support.

Finally, ensuring that self funders have access to the best possible advice. The LGiU has previously highlighted the fact that less than 7% of self-funding citizens are

19 http://www.adass.org.uk (2012) President's blog April 2012

Swindon Borough Council: driving down the cost of living

The Swindon Safe and Warm scheme is an initiative involving a range of local delivery partners that aims to make homes warmer and cheaper to heat and reduce the risk to people from falls and fires. People are targeted based on their vulnerability and risk of death or morbidity due to cold housing. The service provides a heavily subsidised home insulation programme, a free income maximisation service, help with managing fuel debt and energy consumption, a fire safety service and falls prevention support.

accessing or receiving expert and impartial care fees advice and information. As Dorset County Council observed, there is a disconnect between public expectation for access to a universal adult social care service, akin to the NHS, and the reality of means testing. The King's Fund argued that this was resulting in a situation where people are making "disastrous" decisions about funding their care. As we have seen, this results in one in four self funders falling back on state funded care at an annual cost of up to £1 billion.

The key to resolving this issue is receiving independent, expert and timely advice. The Association of British Insurers stated: "The future that we would like to see is where the consumer is aware of their care choices and makes informed decisions about how to get the care they want. This means that they have a financial plan in place to pay for the care they choose, whether it is in their own home, in sheltered housing, or in a residential care home. This process should be seamless for the consumer and their decisions throughout life should contribute and reinforce their financial plans for care".

All authorities were agreed that the provision of independent specialist information and advice was vital. However, it was recognised that maintaining the independence of advice services is important.

Hampshire County Council is working with Trading Standards under the umbrella of Hampshire's Buy with Confidence Scheme to set up a panel of specialist care fee advisers who have been rigorously vetted. A number of authorities and bodies, including ADASS, are referring self-funders to the Paying for Care website. This enables citizens to engage online with expert, impartial and accredited care fees advisers and firms.

3. Acting as a market-shaper

The evidence gathered here shows how, in many authorities, there has been a general move from direct provision to commissioning of services on behalf of local residents. As self-funders become an increasingly significant proportion of recipients of care, local councils will need to play an emerging new role as a market-shaper if they are to have a positive influence on the quality of care received by a significant proportion of local residents. Increasingly, people will look to local authorities as a trusted provider of independent, expert guidance in an increasingly complex care market-place.

There was broad agreement on the importance of the role of local government in market-shaping. London Borough of Sutton argued the main functions local authorities can play in market-shaping include:

Nottinghamshire County Council: monitoring self-funders

In order to ensure that public receive appropriate care fees advice, the council awarded a contract to Capita IB to develop a software solution that will monitor and record the occupancy and vacancies of beds within care homes in Nottinghamshire. The council implemented the care home bed monitoring system from March 2012 for care homes for older people. The system is web-based and will enable people to search for all care homes in Nottinghamshire and find out how many beds are available at any moment in time.

Through this software, the council will receive details when a self-funder has entered a care home and the system also automatically reminds care homes of the importance of self-funders obtaining advice. The software will also send a notification to Paying for Care, a non-profit company, notifying them that an unnamed self-funder has entered the care home. It will then arrange for an independent care fees adviser to contact the care home seeking permission to meet with the new self-funder. It is proposed that the county council works with Capita IB to market and sell the care home bed monitoring system to health and other local authorities.

- setting strategic commissioning intentions, outlining the types of support and services required in the future, in the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS) with health partners
- stimulating and supporting new provision of services including sharing risk with providers for unproven, innovative services
- driving up cost effectiveness to benefit all purchasers, including for people who fund their own care
- improving the quality of services and the standard of provision through workforce development and planning
- developing an infrastructure for people to increase their choice and control of care and support services through information and advice services.

There was agreement, however, that this was an emerging role. As Nottinghamshire County Council noted, market-shaping requires different capacity and skills on the part of local government and the development of new relationships with providers that have been used to a contractual relationship with the local authority. To start this process, Nottinghamshire County Council is taking part in an East Midlands Joint Improvement Partnership project to develop Market Position Statements by June 2012. Mears Group also believed that local government has progress to make. They said that most local authorities currently focus using their purchasing power to define how a provider delivers a service rather than actual market-shaping.

Resolving the tension between ensuring accountability for public spending, and maintaining an innovative care market place, is a key challenge for local government in this area. Birmingham City

Nottinghamshire County Council: market stimulation

The Nottinghamshire micro provider project is a partnership between Nottinghamshire County Council and Community Catalysts. The project supports local people to develop care and support services for residents in order to give people who use services more choice and control over the support that they receive. Micro providers are defined as those providers who: have no more than five paid or unpaid full-time equivalent workers; deliver care or support services to people within their local community; and are independent of any larger or parent organisation. This project worked with Community Catalysts who had already developed and tested a model to increase the number of local micro providers.

Nottinghamshire's project has been in place since July 2010 and there have been 136 enquiries made so far from developing, new or established providers. There are currently 41 micro providers operating across Nottinghamshire who deliver a range of services including: opportunities for people in the daytime; flexible support services in the community; care and support in the home; domestic support services; volunteering and employment support services; direct payment support services; holidays and short breaks; leisure opportunities; and befriending.

Lancashire County Council: supporting all residents

Help Direct is a service in Lancashire which provides advice and information about, and signposting to, mainstream services across the county which are available to everyone without requiring an assessment. It was initially set up in order to ensure that people who did not meet the Fair Access to Care Service (FACS) eligibility threshold in Lancashire had a robust source of assistance.

Help Direct maintains a resource directory known as the Wellbeing Directory which holds details of a wide range of organisations within Lancashire. To complement this, the council has invested in a number of universal services mainly provided in partnership with third sector organisations. Help Direct also signposts people using the Safe Trader Scheme operated in partnership with Lancashire Trading Standards.

All members of the Help Direct Safe Trader Scheme have shown they are committed to treating their customers honestly and fairly by committing to a code of practice and agreeing to work with Trading Standards to resolve any problems if they should occur. Businesses on the scheme are monitored using customer feedback.

Council's submission suggested a route to resolving the tensions between commissioning and market-shaping. With the implementation of Individual Budgets and market-shaping the council will be able to ensure and demonstrate value for money. A current example that is under way is the move to a framework contract where instead of a contracted price for a fixed service, providers will be asked to micro tender on an individual service user basis. Supplier selection will be 40% on price and 60% on quality (that is how well a provider demonstrates that they can meet the service users needs and outcomes).

Other obstacles to a market-shaping role were also recognised. Buckinghamshire County Council argued that a major constraint faced by this local authority is that there is no large scale funding available for market development which necessitates the use of other budgets to develop and steer market development and service development. Surrey County Council argued that market-shaping is made more challenging because approximately 80% of people needing care and support are self-funders but there is a view that Surrey County Council only has contact with people who have critical or substantial needs. The council will as such work harder to have an influence and shape the market to achieve positive benefits for all Surrey residents.

We can see then that market-shaping is work in progress for many authorities but that there are already examples of how councils can use their commissioning power to stimulate and manage a greater diversity of care providers. This process is crucial to create a greater range of options that will allow councils to build upon and extend their current good practice in helping people live independently and manage their finances. Ultimately this will benefit local government and, most importantly, the older people who need care and support.

Key findings

The role of local authorities in caring for older people is undergoing a rapid evolution. Authorities are moving from a delivery role to one that is centred on commissioning, supporting and capacity building. It is vital that local authorities refer people to good advice, create clear pathways for care recipients and stimulate a market that provides choice and quality. The case studies presented here and throughout this report show how many local authorities are already, within the scope available to them, starting to build a system for the future.

By helping people live independently for longer, they are managing the demand for care. By helping people stay financially independent, they are managing the cost of care. And, by shaping social care markets, they are stimulating innovation and increasing the range of options that are available both to individuals and to public agencies.

These sorts of activities should be emulated across the country. None of the respondents to this Inquiry suggested that this new role for local authorities was sufficient in and of itself to meet all the challenges facing the adult social care system. But they do point towards real results and real savings that can achieved in the short and medium term.

More importantly by addressing these three key functions, local authorities lay the foundations for the long-term reform of the system we examine in the next section.

“If we don’t provide that early intervention and support that actually enables those things, to enable the person to feel comfortable to live independently, we get driven down the route to high levels of crisis intervention.”

5 Where do we go now? A system fit for the future

Prevention

A dominant theme of the evidence received by the group was about the benefits of a shift to a more preventative system: both in terms of driving down the cost of services and for delivering better outcomes for service users.

"If we don't provide that early intervention and support that actually enables those things, to enable the person to feel comfortable to live independently, we get driven down the route to high levels of crisis intervention." [20]

It also became clear that local authorities are already doing a lot of innovative work to drive a preventative agenda. As we saw earlier they are already saving 4.1% a year by investing in preventative services and service redesign.

The evidence presented to the Inquiry included many examples of how local authorities were already using preventative approaches.

Halton Borough Council and NHS Halton and St Helens have developed a useful hierarchy of preventative services. It defines the three distinct areas of prevention.

- **Primary prevention – promoting wellbeing:** This is aimed at people who have no particular social or health care needs. The focus is on maintaining independence, good health and promoting wellbeing.
- **Secondary prevention – early intervention:** This is aimed at identifying people at risk and to halt or slow down any deterioration, and actively seek to improve their situation.
- **Tertiary prevention:** This is aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus is on maximising people's functioning and independence.

There was a recognition that self-funders must be included in the drive towards preventative services. Again, as Surrey County Council pointed out, approximately 80% of people needing care and support in the authority are self-funders. London Borough of Sutton argued that too many of these self-funders are choosing to go into residential care when they could remain supported in the community, often at less cost, because neither they or their friends and family know what options are available now – particularly with the advance in assistive technologies. Hertfordshire County Council suggested that we should aim to ensure that people funding their own care are equally motivated to prevent deterioration and recover and that they have information about the things that can help with this.

However, since most of the savings from preventative services for self-funders accrue to the NHS, there is an urgent need to think through how this can be financed in

20 Maria da Silva, Chief Operating Officer for Whittington Health, oral evidence to the Inquiry

Essex County Council: reablement service

Essex County Council first introduced a reablement service in April 2008. Initially the service took people being discharged from hospital but over time the numbers admitted from the community have grown. Overall, the numbers of people admitted to the service have increased year on year from over 1,900 in 2008-09 to over 2,700 in 2009-10, over 3,100 in 2010-11 and over 3,800 in 2011-12. In the last four years almost 5,000 people have left the reablement service with no need for ongoing care support from the county council.

As well as the improved quality of life, there have also been financial benefits for these people. Had they received care support, it is possible they would have been required to make a contribution towards the cost of that care (under the "Fairer Charging Regime"). They estimate that in 2011-12 these people would otherwise have been required to contribute £1.8 million towards the cost of their care. In 2012-13, that is projected to increase to £2.4 million.

The direct impact of reablement for the county council is that there is a requirement to provide less care to citizens with a consequential reduction in costs. They estimate that during 2011-12 the reduction in gross care costs is almost £12 million, and that will increase to over £16 million in 2012/13. However, as a consequence of these reductions, the county council will receive reduced income from charges (as described above) of £1.8 million in 2011/12 and £2.4 million in 2012/13.

The net saving in care costs for the county council is therefore estimated at £10 million in 2011/12 and will rise to £13.6 million in 2012/13. The council estimates that during 2011/12 there were at any time around 2,000 to 3,000 people not receiving care who without reablement would have been receiving care. In addition to the care costs avoided by the county council, there will also be no management on-costs for these people. This cost has not been quantified but will be significant.

partnership with health. One option may be for these services to be funded through the Health and Wellbeing Board (see p31-35).

Integration

Integrated care means different things to different people. At its heart, it can be defined as an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well co-ordinated around their needs. To achieve integrated care, those involved with planning and providing services must impose the user's perspective as the organising principle of service delivery.[21]

There is a growing recognition of the efficiency savings and service

21 King's Fund and Nuffield Trust (2012) *Integrated care for patients and populations: improving outcomes by working together*

Trafford Council: telecare

In 2010, Trafford launched their Telecare Transformation Programme to contribute to the support for older people to live longer in their own homes with a better quality of life.

An example of this is Mr A, who had dementia, lived with his wife, but had a high risk of experiencing falls. Mr A was admitted to hospital with a minor infection. Hospital staff told the family that, given the risks, the only sensible discharge solution for Mr A was residential care. The family were unhappy with this and a telecare assessment was arranged by the social worker.

Through the use of bed, chair and falls sensors and a 24-hour pendant alarm, Mr A was able to return home. The use of the telecare option in this case prevented admission to residential care representing a saving of approximately £25,000 per annum.

The council has also invested in Just Checking, which is an assistive technology that can map the movement of an individual or log the activity of a number of individuals. One example of the use of this technology is monitoring the movements of a number of older people within a sheltered accommodation scheme over a period of weeks. This enabled the production of activity charts which allowed the correct allocation of staffing resources.

By linking information provided through the Just Checking scheme with other technology, staff time could be reallocated from more expensive night-time support to more beneficial day-time activity. The use of the telecare option in this case represented a saving of £10,388 per year.

improvements that result from integration of primary care and social care. Encouragingly, many authorities reported effective joint-working with their PCT including at a budgetary level.

Sunderland City Council, for instance, reported that Section 256 agreements, which allow PCTs to transfer money to local authorities to facilitate the joint delivery of services, are in place over a diverse range of services including mental health, carers support, dementia, hospital discharge, safeguarding adults, telehealth and reablement services.

The 2012 ADASS budget survey has found that £622 million of NHS money has been invested into social care in 2012-13. £284 million has been used to offset pressure on services, £148 million to invest in new social care services and £149 million allocated to working budgets.[22]

The Inquiry heard different perspectives on how the integration of primary care and social care could be strengthened. The Health Select Committee on Social Care has pointed out that integration has been identified repeatedly in the past 40 years as an essential tool to improve outcomes for

22 Association of Directors of Adult Social Services (2012) *Budget survey 2012*

individuals and communities. In order to overcome the barriers to integration, the Select Committee recommended the creation of a single local commissioner. Many respondents, however, argued that it was not structures *per se* that were important.

Lancashire County Council, for instance, criticised the tendency to see integration as an an end in itself. The council points out that in many cases it is not so much integration as alignment and effective collaboration which avoids the bureaucracy and structure issues associated with integration.

Several contributors to the Inquiry felt that integration needed to go beyond social care and health and needed to actively engage with other service areas such as housing, leisure and environment, which all contribute directly to wellbeing, and have an active role in helping people to lead healthy, independent lives.

The National Housing Federation (NHF) noted that poor housing conditions increase the risk of severe health or disability by up to 25% during childhood and early adulthood.

Despite this, housing has traditionally been seen as separate from health provision. Encouragingly, the NHF reports that many organisations have been successful in attracting investment from Primary Care Trusts as part of local strategies to reduce falls, winter deaths and hospital visits.

The Leicester Housing Association has developed one of the country's first one-stop shops for health and social care in partnership with Leicester City West Primary Care Trust, Braunstone Community Association and Leicester City Council. It comprises a cafe, GPs' surgeries, community nurses, physiotherapy, dentists, chemists, opticians, mental health advisors, drug and alcohol counsellors and family planning services.

Some challenges associated with resource reductions and changes to structures were reported. In the short term, several local authorities expressed concern that their PCTs were changing the basis upon which they make the Continuing Care Assessments that govern the provision of NHS-funded care. This has a consequent cost shunt to the authority as the provider of last resort.

In the medium term, there was concern about integration at a strategic level. Birmingham City Council confirmed a strong preference for a comprehensive approach to integration. However, it highlighted some realistic constraints upon this. It noted that there are real opportunities for commissioning with GPs and developing the use of individual budgets across health and care that will stimulate new and different offers to meeting needs. However, this is a gradual process and that will need to be developed over time in agreed priority groups and based upon clear evidence.

Practical concerns were also expressed around integration of services. East Riding of Yorkshire Council highlighted two barriers to integration. First, there are several new builds in progress in East Yorkshire where it would be beneficial to have co-located services: the barrier is additional revenue costs. There is a standard cost formula per square foot in the NHS that is cost prohibitive for adult social care. Second, information sharing and confidentiality. The council notes that adult social care can be excluded from full participation in multidisciplinary team meetings as a result of confidentiality. The authority also observes that the review of Caldicott Principles could help support good information sharing. Bath and North East Somerset pointed out that, although reforms emphasise the value of integration, governance arrangements, structures, guidance and authorisation processes at present do not.

Bristol City Council: PCT and local government integration

Intermediate Care and Reablement Services Bristol Community Health (BCH) and the Health and Social Care Directorate (HSC) of Bristol City Council have developed a comprehensive range of intermediate care services which include REACT, an admission avoidance service located in the A&E Departments of the acute hospitals and a rapid response service.

The council has clear and robust joint governance arrangements with BCH. These include a joint strategic manager's post and a Partnership Board. The aim of the services is to ensure that unnecessary hospital and residential admissions are avoided and that patients receive high quality clinical input in their own home, whenever possible. The rapid response service is usually provided for a period up to 10 days. There is also access to step-up residential or nursing home placements, when required. The service also includes a re-ablement team.

The philosophy of the whole service is to help individuals regain maximum independence as soon as possible. In contrast to many intermediate care services, its focus is primarily on hospital avoidance rather than facilitating hospital discharge, with 60% of activity relating to hospital avoidance. In order to achieve this balance, good relationships have been nurtured with primary care over a period of time so that GPs are now the main referrers to the service.

There has been a strong partnership between HSC and BCH for many years that allowed the service to grow and develop. It has also enjoyed settled management with a clear focus on the aims and the performance management of the service. It has agreed targets with commissioners on the conditions that the service will focus on. These are drawn from the ambulatory care sensitive conditions.

Staff code their activity when treating these conditions using the same codes, HRG (Hospital Resource Groups) that the acute hospital use and which then allows the service to accurately compare the cost of treatment in the community against the cost of treatment in a hospital.

Latest figures (April 2012) show that the reablement service is reducing home care hours by an average of 6.5 hours per person per week. The whole intermediate care service makes efficiencies for the PCT and the local authority. In 2008-2009, the rapid response element made savings of £4.3 million across health and social care.

Halton Borough Council: working with Clinical Commissioning Group

Halton Clinical Commissioning Group (HCCG) and Halton Borough Council (HBC) have agreed a Shadow Section 75 Partnership Agreement for joint commissioning across a range of areas, including urgent care.

Urgent care has had a significant profile at the national and local level for a number of years and has been the subject of a raft of national and local reviews, reports, evaluations and initiatives. This work has been overseen by a range of committees, boards and governance structures. An urgent care board has been set up which will be chaired by the Operational Director Prevention and Assessment from HBC with the lead GP for urgent care.

Representation includes: managers from the Clinical Commissioning Group, Halton Borough Council, the acute hospital sector and Warrington Health economy. The Board will have a focus on reviewing the various pathways and commissioned services within the remit of urgent care and work closely with colleagues in the surrounding boroughs and Mersey Cluster to ensure robust arrangements are in place in relation to all aspects of urgent care commissioning, contract management, evaluation, service design and redesign.

The very different approaches from Bristol, Halton and Buckinghamshire *(see above and overleaf)* share some core features: they use prevention as a way of driving down cost and delivering better outcomes; they start from a user centred perspective; and they involve structured integration across different parts of the public sphere.

In particular, the Buckinghamshire County Council example relies heavily on the co-production approach through the volunteer hub as a means to lever additional, no-cost resources from service users and the wider community to deliver care services alongside provision which is delivered by professional care providers.

These are examples of local government and its partners working in the most effective way. However, this approach is not universal. The King's Fund noted that integrated care has been a recurrent goal of public policy under successive governments for more than 40 years, but less than 5% of NHS and social care budgets are subject to joint arrangements and there are wide variations across different parts of the country in the quality and achievements of joint working.

Care providers, meanwhile, expressed some scepticism about the way in which care was actually commissioned in practice. For example, Mears executive director Alan Long argued that, while outcome-based commissioning was much talked about, the reality was all too often of block-booking contracts and competition based around the hourly price of care. The effect of this, he argued, was a race to the bottom which stifled innovation and drove down the wages of care workers.

Several contributors expressed concern that local government was not rewarded financially for investing in preventative services. Many of the benefits from preventative services flow to the NHS,

Buckinghamshire County Council: joint investment in prevention

Following a £4 million investment from its Primary Care Trust, Buckinghamshire County Council recently embarked on a journey to transform its social care services by developing a prevention programme that focuses on those adults who are at risk of needing more intense social care or health support in the near future.

Using data gathered from Primary and Social Care, a key target group of around 7,000 people has been identified. The prevention approach places these individuals and the community and local organisations that surround them at its heart and is designed to support and encourage people to lead better and more independent lives.

Through a process of co–production Buckinghamshire County Council and its many partners have sought to: overcome challenges that exist within the partnerships and work practices; learn from local, national and international evidence and good practice; spend time with users using "day in life" explorations to better understand their needs and abilities; and develop and test out new models for prevention. The aims are motivating and enabling individuals to play active roles in their communities making the most of their abilities; connecting people to each other, their communities and services; bridging between communities and services to create mutually supportive communities and blurring the boundaries that can prevent open access and inclusive services; intelligence-gathering to evidence impact, target resources, share good practice; and maximising existing resources to create the greatest impact of prevention.

This is achieved through eight Community Liaison Officers (CLOs) who are the bridge between the informal and formal sectors so as to build community and organisational capacity to establish new community based services and enhance existing ones. 14 Community Practice Workers (CPWs), meanwhile, will be based within GP practices, the prime source of referral. CPWs will be responsible for identifying, motivating and enabling individuals to take active part in their surrounding communities as well as access or develop support structures around them. This will be supported by the creation of an extensive intelligence hub. Its purpose will be to identify and collate core data sets and information, feeding this into future needs analysis and enabling future resources to be targeted through evidence based interventions and support.

A volunteer hub will also be developed to support voluntary organisations, volunteers, and policy makers to make better use of existing and potential volunteer capacity and value across the county. It will support and deliver work to promote volunteer numbers, improving experience and enhancing informal and formal support services.

where money is currently being spent unnecessarily in acute care.

London Borough of Havering highlighted the fact that a clinical audit which took place in 2011 in Barking, Havering and Redbridge hospitals found that a number of emergency admissions could be avoided if pathways for key conditions across the primary and secondary emergency care pathways were developed. It was recognised that unnecessary admission to hospital can increase levels of dependency and expose people to further risks such as those of infections. The council has therefore agreed with health partners and neighbouring authorities to take forward the development of an integrated care strategy which includes a 10% reduction of hospital admissions due to falls.

The recognition that the creation of Health and Wellbeing Boards represents a significant opportunity for effective integration of services extended to acute services. Leicester City Council explained how its shadow Health and Wellbeing Board supports and facilitates integration of services at a more operational level. Work on the acute care agenda is channelled through a multi-agency Emergency Care Network. This has supported a number of joint working initiatives.

For example, health and social care coordinators, employed by the council but mentored by GPs, work in local practices to support long-term conditions management, hospital in-reach for the practice's admitted patients and discharge coordination and follow up. This has resulted in improved continuity of care, quicker discharge and reduced re-admissions to hospital.

Evidence submitted to the Inquiry suggests that savings from preventative services to acute care can be substantial. A Personal Social Services Research Unit (PSSRU) evaluation of Department of Health-funded Partnership for Older People Projects, which ranged from low level services to more formal preventive initiatives, found that every extra £1 spent delivered an average £1.20 additional benefit in savings on emergency bed days. The savings flowed from a 47% reduction in overnight hospital stays and a 29% reduction in the use of accident and emergency departments.[23]

There remains a question as to the mechanism through which integrated preventative spend can be managed. Many of the experts who submitted evidence to this inquiry were optimistic that Health and Wellbeing Boards could play this role. Others were anxious that their powers as currently constituted were too weak.

Integration became a dominant issue as the Health and Social Care Act progressed through its Parliamentary stages. The Future Forum was asked to focus on it for its second report; Monitor was given statutory power to impose integration of services as a condition on providers; and the role of Health and Wellbeing Boards was strengthened to deliver it.[24] However, the Act does not create any new integrating funding streams. Health and Wellbeing Boards will continue to rely on Section 75 flexibilities.

There are also, of course, still significant barriers and challenges to making integration work effectively. The financial pressures on health and social care may give an added incentive but could make collaboration more difficult. The different funding regimes for health and social care will remain a significant barrier to integration. The Health and Social Care Act could, itself, hinder integration, with more competition further fragmenting service delivery. Local commissioners, including councils, will need to balance the

23 PSSRU (2010) *The national evaluation of partnerships for older people projects*
24 NHS Future Forum (2012) *Integration: a report from the NHS Future Forum*

government's objectives of greater choice and competition with the government's other stated aim to deliver more integrated care. Evidence to the inquiry identified further challenges, such as changes in NHS structures and practical barriers around areas such as technology and data.

Despite these challenges, there is a strong belief in local authorities that Health and Wellbeing Boards have the potential for achieving a step change in joining up health, public health, social care and related services. Yet the powers of Health and Wellbeing Boards are limited and their role is seen by the government as being a key influencer on decisions around integration and commissioning, rather than being able to direct those decisions.

The Health Select Committee in its recent report on social care strongly believed that Health and Wellbeing Boards could be the key to progressing integration:

"Health and wellbeing boards' role should be strengthened. They should agree commissioning plans, be able to refer concerns about commissioning consortia's commissioning plans to the NHS Commissioning Board and contribute to their annual assessment." [25]

New local models creating a single commissioning process need to be developed to replace a system where services and budgets for many people, particularly the elderly and those with long-term conditions, are fragmented and incoherent. Health and Wellbeing Boards should be developed as the holder of a single, integrated budget.

In their evidence to this Inquiry, the LGA suggested that we need to think about commissioning organisations existing within and alongside Health and Wellbeing Boards, with Clinical Commissioning Groups (CCGs) and councils delegating the commissioning function to this body.

Key findings/recommendations

It is clear that any system that is viable for the long term must be significantly geared towards prevention. There was near unanimity from all the experts who gave evidence to the Inquiry. The success of the examples we have looked at also highlights the value of this approach.

Maria da Silva, Chief Operating Officer, Whittington Health, argued: "Integration is especially important when cash is stretched. The PCT, for example, invested some of its funding into local authority and community services, which delivered more responsive services and efficiencies. Pooled budgets for intermediate care services has saved money on delayed discharges and allows people to remain in their own homes. Mutual learning has been beneficial to all sides – social care can help health improve user involvement; health can provide lessons for social care in clinical governance."

The improvement in joint working hasn't been easy. Maria pointed out that a lot of time has to be spent in developing relationships, in persuading people

25 Health Select Committee (2012) *Fourteenth report of the session 2010-2012: social care*

it will work. It requires openness and transparency and the involvement and interest of service users.

It is also important that we see a funding system that supports this move towards prevention. We cited earlier evidence from Sean Gallagher at DOH who argued that "the funding system, needs to support the principles about what a good care system should offer to the people".

Looking at the evidence received by this Inquiry, and the case studies cited in this report, we believe that it is possible to create a virtuous circle of funding and function whereby funding drives prevention, this generates savings and these in turn bring further resource into the system to cope with growing demand.

In many ways, this is a common sense point. We know that a hospital admission for a broken leg costs many hundred times more than the £30 grab rail that prevents the fall. Too often in the current system accident and emergency admissions function as a safety valve. This is not only grossly inefficient, it is failing vulnerable users forced to wait for a critical incident before their needs are addressed. When a two-week stay in hospital can cost up to £14,000 it is clear that a move towards prevention can unlock huge resource.

This is not a new idea of course. The Health Select Committee in its recent report recommended a move toward a more preventative system and it has been a consistent feature of plans for reform for the last two decades at least.

Despite all the good work that we have seen they are doing, neither local authorities nor care providers can achieve a fully preventative system by themselves. It may seem like common sense but it requires political bravery and structural and budgetary reform to achieve.

We believe that serious consideration should be given to passporting money across from NHS to prevention in next spending review. As noted above, there is already good practice to draw on in primary care with £622 million of NHS money invested in to social care in 2012-13. The challenge is to deepen this, and advance in to acute budgets.

The evidence submitted to this Inquiry suggests that if even the amount of money currently underspent within the NHS budget (£1.5 billion in 2010) were to be re-allocated towards integrated preventative services, we would be able to close the care funding gap we have identified.

It is difficult to pin down these figures with precision based on current data, but all the case studies presented to this Inquiry show how significant savings can be released and an indicative figure may be derived from the PSSRU study cited on page 31. If a saving of £1.20 is realised in the NHS for

every £1 spent on preventative care, then the additional £634 million required to close the care funding gap would generate a further £760 million saving within the NHS. This money should be diverted towards preventative care as soon as is practicable, because it is fundable from the current underspend, this can be done straight away ahead of any savings accruing.

There remains a question as to the mechanism through which integrated preventative spend can be managed.

The Inquiry has concluded that Health and Wellbeing Boards do need strengthened powers and a more clearly defined role, particularly to ensure that they are able to deliver a real shift from a acute based approach to a more personalised and preventative one.

Health and Wellbeing boards were envisaged as being a principal vehicle for bridging the democratic deficit in health.[26] Health and Wellbeing boards are also, of course, the place where health is brought together not just with social care but with public health and services such as housing and planning which are critical to the wellbeing of individuals and communities. They are, therefore, the most appropriate body to hold the budget passported from the NHS for prevention as recommended by this inquiry.

There are barriers to integration that persist regardless of the opportunities presented by Health and Wellbeing Boards – such as the payment by results tariff for funding hospital activity that has incentivised hospitals to increase admissions and undermines collaborative working to develop and deliver new forms of integrated care. As the King's Fund points out, stronger incentives are needed if health providers are to collaborate to address the fragmentation and duplication in care. Commissioning for patterns of care and for cohesive patient pathways need to be at the top of the agenda for a reformed health and social care system.

Nearly half the funding allocated from the NHS budget to strengthen joint working between the NHS and social care has had to be spent on protecting existing social care services. Having funding passported to the Board would ensure that this funding is used to promote joint working and commissioning. Clearly this needs to go alongside a sustainable funding settlement for social care.

An annual injection of NHS money into preventative activity, directed by Health and Wellbeing Boards, would be a positive, even if limited, step, towards integrated commissioning, giving priority to social care and other wellbeing services that support prevention and reablement and would trial new innovative ways of working. The government needs to also consider how the devolution of commissioning streams could be advanced more quickly than they are likely to be under the current system.

26 Department of Health (2010) *Liberating the NHS: increasing democratic legitimacy in health*

Although the role of the boards was strengthened following the Future Forum's second report, there is still concern that their influence over CCG commissioning plans will be too limited and that they will have little or no influence over the NHS Commissioning Board. The NHS Commissioning Board and the Health and Wellbeing Boards are 'encouraged' to work together and the CCGs and local authorities are required to 'work closely together'. CCGs have to involve the Boards in preparing or revising their plans and the Boards can refer the plan back to the CCG or upwards to the NHS Commissioning Board if the Health and Wellbeing Board believes that the CCG commissioning plan does not pay due regard to the joint health and wellbeing strategy. The NHS Commissioning Board is legally bound to encourage commissioners to work in an integrated manner and to provide advice and support to encourage pooled budgets.

Are these requirements strong enough if the boards are really going to make commissioning decisions locally and democratically accountable?

The APPG supports the position of other organisations, notably the LGA and, indeed, the Future Forum, that the boards should have the right to sign off CCG commissioning plans (which is not the same as a veto). Although it is unlikely that many CCGs plans will have to be referred back – if relationships are developed as they should be – there could be cases where the Health and Wellbeing Board and the CCG cannot come to an agreement about priorities. In these cases the democratic body should take precedence. The Secretary of State could have the power to direct the CCG to consult further with the Health and Wellbeing Board and to amend their plans so that they take proper account of the Board's objectives, particularly around integration and prevention.

The position with the NHS Commissioning Board is even more problematic. Given the powers of the NHS Commissioning Board and the likelihood that they will be directly commissioning up to 30 per cent of the total NHS budget, it is crucial that Health and Wellbeing Boards have sufficient powers to influence the NHS Commissioning Board's plans that affect the local population, and that they have the right to challenge the plans if they are not sufficiently in keeping with the joint health and wellbeing strategy. The NHS Commissioning Board should have a duty to cooperate with the Health and Wellbeing Board in the exercise of its functions and specifically in relation to the promotion of integration and collaborative working.

Taken together the reforms outlined above would result in a whole system approach in which spend could be managed across services and directed to the point where it could do the most good. Funding would both drive prevention and be generated by a preventative approach.

Finally, the use of Health and Wellbeing Boards with elected local politicians sitting on them to manage this system would provide a crucial accountability to local people.

“The Dilnot Commission was set up to answer a question that has become increasingly limited when seen against the scale of the challenge that crops up in social care systems.”

The Rt Hon Stephen Dorrell MP, Chair of the Health Select Committee

6 Funding the system

A system that was focused on prevention would be a more efficient use of resource than the present system. This group believes that diverting money from acute care to prevention would also create savings.

There are, in principle, a range of other ways in which extra resource could be brought into the system to close the funding gap: individuals could be asked to make a greater contribution to their care costs; the government could decide to spend a greater amount on care either by taking money from other areas of spending or by increasing taxation; or further savings could be made.

As we have seen, it is important that we establish a dynamic link between the way the system is funded and the way it functions.

The most developed set of proposals for funding reform currently under consideration are those of the Dilnot Commission.[27] The majority of organisations giving evidence to this Inquiry commented on Dilnot's recommendations. This led the Inquiry to consider Dilnot's recommendations and to comment upon them.

Dilnot's task

The Dilnot Commission was asked to make recommendations on how to achieve an affordable and sustainable funding system for care and support for all adults in England, both in the home and in other settings. The Commission was asked to examine and provide recommendations on:

- how best to meet the costs of care and support as a partnership between individuals and the state
- how people could choose to protect their assets, especially their homes, against the cost of care
- how, both now and in the future, public funding for the care and support system can be best used to meet care and support needs
- how its preferred option can be delivered.

The Commission was therefore given a somewhat restricted (though clearly crucial) remit. Its final report does include thoughts and some recommendations on issues such as prevention and aligning social care with other services and the NHS but its key recommendations are about future funding, not about delivery or fundamental reform of the system. It is not about how social care relates to the wider society and communities. It is primarily concerned with how social care costs should be paid for and the relative responsibilities of the individual and the state. It does not make recommendations on the totality of the resource needed.

A reminder of Dilnot's main recommendations

The centrepiece of the reform package is a proposal to share the costs of care in later life between individuals and the state, with

27 Commission on Funding of Care and Support (2011) *Fairer funding for all*

individuals paying for their own care until they reach a 'cap', after which the state pays for their care.

An individual's lifetime contributions towards their care costs are currently potentially unlimited. Dilnot proposes capping these somewhere between £25,000 and £50,000. This is a 'limited liability' model of social insurance – those who can afford it are expected to pay the 'excess', but no-one will be expected to lose all their savings and assets in order to cover the costs of sustained high-level care and support (often in residential care).

The review makes the following main recommendations:

1. A cap on the lifetime contribution of individuals to their social care costs (residential or home care). The review suggests a range between £25,000 and £50,000 and proposes £35,000.

2. The level of assets which people should be able to retain while being eligible for state funding for residential care should increase from £23,250 to £100,000.

3. People with care and support needs from childhood cannot be expected to plan for their future care needs and should be eligible for free state support.

4. Universal disability benefits for people of all ages should continue but the government should consider how to align benefits with the social care funding system and Attendance Allowance should be re-branded to clarify its purpose.

5. People should contribute a standard amount to cover their food and accommodation in residential care – £7,000 to £10,000 a year is proposed.

6. Eligibility criteria for service entitlement should be set on a national basis with an improved framework. In the short term, the report suggests a national minimum threshold of 'substantial'.

7. The government should develop a major new information and advice strategy to help people when care needs arise.

8. The government should review the scope for improving the integration of adult social care with other services in the wider care and support system, particularly health.

Responses to Dilnot's call for evidence

The Commission published a summary report to pull together the major themes raised consistently by organisations and individuals in response to its call for evidence. This indicates what key players wanted from a future reform of the system. Some will have amended their demands following Dilnot's actual report as they were then having to respond directly to his recommendations.

The Commission says that there was general support "for the direction of travel" they had previously outlined. There was considerable support for a partnership funding model; the safety net needed to continue; and any reforms must support working-age adults as well as older people.

Overall, the Dilnot report was welcomed by individuals and organisations involved in adult social care. Major older people's and disability charities, national care provider bodies like the English Community Care Association, insurance provider Partnership and also council bodies including the Association of Directors of Adult Social Services all supported the thrust of the proposals with some reservations on the details. The NHS Confederation welcomed the proposals. The Labour opposition supported the recommendations.

The Health Select Committee, in its report of February 2012, was clear that it believed the current social care system was inadequately funded and that the squeeze on local authority budgets over the next four years would worsen.[28]

The committee agreed with Dilnot that the balance of funding was wrong and commissioners need to rebalance the entire expenditure on services for older people across the NHS, social care, housing and welfare. It was convinced that there is a broad consensus in favour of implementing the main findings of the Dilnot report.

The committee itself accepted the case for the principle of capped costs. However, it argued that:

"It is important that the future shape of social care is not dominated by a debate about the technical details of funding. It is essential that services are shaped by the objective of high quality and efficient care delivery, and the funding structures are fitted around that objective, not vice versa." [29]

Although the committee supported the implementation of the main recommendations of Dilnot, it believed the narrow terms of reference given to the Commission meant that the more fundamental issues about the need for a more integrated care model were only addressed in passing by Dilnot.

Some organisations, such as the social care market analysts Laing and Buisson, were not convinced that all of Dilnot's recommendations would work. They argue that, currently, self-funders often cross-subsidise the relatively low fee rates paid to providers by local authorities and protect providers' bottom lines to some extent.[30] As the Dilnot reforms would reduce the number of self-funders, by capping private care costs, this could reduce the overall level of fees paid to providers and cause issues for providers.

Some commentators, such as Director of the Institute of Public Policy Research Nick Pearce, question whether people, left to their own devices, will self-insure themselves against the costs they would be responsible for.[31] Representatives from the financial services sector have echoed this argument.

The Office for Public Management, meanwhile, expressed concern that the suggested limit on residential care living costs per individual of £7,000 to £10,000 could lead homes to squeeze spending on things like food, activities and the physical environment.[32]

Others questioned the Dilnot Commission's central claim that its proposals would protect people against potentially catastrophic costs. Organisations such as Relatives and Residents Association and FirstStop Care Advice argued that the fact that the cap on costs does not apply to general living costs in residential care could lead to individuals still facing significant costs.[33]

Some user groups still feel that care should be funded out of general taxation. However, the terms of reference for the Commission directed it away from exploring this option.

Finally, some commentators have argued that the proposals are regressive. Modelling shows that the biggest gains in cash terms accrue to the wealthiest 20% of the population under Dilnot.[34] It should be noted, however, that an element of regression is to some extent inherent in attempts to extend public funding for social care to a broader cross-section of society.

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28 & 29 Health Select Committee (2012) *Fourteenth report of the session 2010-2012: social care*

30 - 34 http://www.communitycare.co.uk (2011) *Dilnot reaction: the cheerleaders, the sceptics and the downright hostile*

The cost of Dilnot

The Dilnot Commission's recommendations, the points outlined above notwithstanding, remain by far the most developed funding solution currently on the table.

Importantly, they are based on the principle of a partnership model for the funding of care. This matters for two reasons.

First, because it was made very clear by witnesses to this Inquiry that the option of a totally publicly funded care service, at present, is neither economically or politically realistic. As Lord Lipsey, a leading figure in the care debate has noted, the appetite for the large increase in taxation that would be required to fund a national care service is extremely limited. The furore over the so-called "granny tax" contained in the 2011 budget, which was in fact an end to a tax break for the elderly with a relatively modest impact rather than a new tax *per se*, clearly demonstrates this political reality.

Second, it takes account of the needs of all care users. The Centre for Social Justice has argued, in a recent report, that the current plight of care services users in the state sector is so extreme that "the government should deal with their needs first, before relaxing rules that require better-off pensioners to reduce their assets to below £23,250 before they are entitled to help from the state".[35]

However, as Lord Lipsey has pointed out, the current financial consequences of entering long-term care mean that a significant proportion of older people who have care needs put off entering care and endure consequent suffering.

The Dilnot Commission's proposals would solve some key challenges associated with the delivery and funding of adult social care. Significantly, the combination of the cap on an individual's contributions to care costs at the suggested level of £35,000 and raising the means-test threshold means that no-one would lose more than 30% of their assets.

However, implementing the Dilnot Commission's recommendations in full would require a significant investment from central government. The Commission estimates that its recommended changes to the funding system would require £1.7 billion in additional public expenditure (0.14% of gross domestic product (GDP)) if the cap on individual contributions is set at £35,000, rising to £3.6 billion (0.22% of GDP) by 2025/6.

Funding Dilnot

Numerous options exist for raising the revenues required to meet the costs associated with meeting the Dilnot Commission's recommendations. In a recent comprehensive review of the available options, the Nuffield Trust recommended that the government could consider using part of the £1.5 billion NHS under-spend generated in 2011/12.[36] A more far-reaching reform would be to review the balance of spending across health, social care and welfare payments.

The Nuffield Trust argues that the government could consider shifting some of the health budget towards social care and use some of the money spent on welfare benefits used by better off older people such as the winter fuel allowances.

More radically, the PSSRU has noted that the government could consider changing the capital rule that excludes housing equity from the funding of domiciliary care. This would save in the order of £2 billion per

35 Centre for Social Justice (2012) *Transforming social care for the poorest older people*
36 The Nuffield Trust (2012) *Reforming social care: options for funding*

year but would, of course, have a significant financial impact on those who currently receive domiciliary care.

One of the most significant problems with implementing Dilnot's proposals as they currently stand is the extent to which their impact varies depending on the average value of the local housing market.

The most significant way in which people currently contribute to their own care is by drawing on equity in housing that they own. In areas where house values, and thus average equity, are higher people are currently contributing more to fund their own care than they would if Dilnot's cap were applied. Implementing Dilnot would therefore transfer cost from these individuals to the local authority.

Hampshire County Council, for example, estimates that costs to the authority of implementing Dilnot would be in the range of £65.8 million to £106.5 million per annum with one-off costs of £11.6 million. This should be seen in the context of an overall Adult Services budget of £310 million.

In areas of low housing value, in contrast, it is Dilnot's proposal to raise the asset threshold after which people fund their own care which will increase costs for the council. If the threshold is raised to £100,000 then all those with house values between £23,500 and £100,000 will have to be funded by the state. Sheffield City Council argued that an asset disregard of up to £100,000 might have a significant impact for northern councils with low value housing markets. Approximately 30% of Sheffield's owner-occupied housing has a value of less than £100,000.

The cause of this complex regional variation, and the potentially regressive nature of the proposals, is the imposition of a numerical cap on contributions to care costs that is not sensitive to local variations in asset values. One possible solution, that would take account of this variation, is to impose a percentage rather than a nationally-determined numerical cap as suggested to the inquiry by Sheffield City Council. This could be set at 30% which is the fraction of a person's assets that the Commission sought to protect.

However, implementation of a regionally variable cap raises issues about fairness and universal entitlement and would require considerable political courage in a system traditionally sensitive to 'postcode lottery' issues.

The Dilnot Commission estimates that, if its recommendations are implemented in full, no one would have to spend more than 30% of their assets to fund their care. It is important to note, though, that while the Dilnot proposals cap an individual's exposure to care costs they do not limit the exposure to 'hotel costs' (accommodation, food etc).

Moreover, the protection against care costs is not as complete as it first appears for two further reasons.

First, because the local authority only has to pay care costs at their standard maximum level after the individual has reached the £35,000 cap, but many people will be receiving care that costs more than that and will have to make up the difference from their own resources or move to a cheaper facility.

Second, because Dilnot does not change the lower means threshold of £14,250. People with assets of between £14,250 and £100,000 will still have to make some contributions towards their own care. This is known as the taper and it is currently set at £1 per week for each £250 of assets over £14,250. So under Dilnot someone with assets of £100,000 would still find themselves liable for £343 a week in costs.

These factors also further increase the regional variance in the impact of Dilnot's

proposals as the cost of care varies significantly around the country.

Even if Dilnot were adopted in full, therefore, individuals could still find themselves paying very substantial costs. As most users do not understand the detail, and do not distinguish between care and hotel costs, this is likely to lessen the meaningfulness of the proposals for many people.

It is also important to recognise that the cost of the Dilnot recommendations do not have a fixed price tag. The King's Fund has argued that the government could consider a phased introduction of the capped cost model with the level of the cap recalibrated as economic conditions improve.

In the short term, raising the cap to £50,000 coupled with a higher cap of £10,000 for living costs, could see the cost of implementing the recommendations fall to £800 million from £1.7 billion.

In the long-term, however, this model assumes that economic growth will outstrip demographic growth and associated costs. This may not be feasible.

At the time of writing the government is expected to endorse the principle of a cap and a revised asset threshold but defer detail on funding. Whether Dilnot is implemented partially or in full, however, individuals will still find themselves having to meet substantial costs.

As we have seen almost all respondents to the Inquiry were clear that care costs would need to be met by a combination of state and personal funding.

None of the possible options for funding reform alter that. It is therefore essential that the recommendations in this report about how local government can help people get advice about the best use of their assets be taken up and extended.

Key findings/recommendations

As we have seen, Dilnot's recommendations provide a well thought out way forward in the medium term that commands much support across the care sector.

They are very good at addressing some aspects of the problem: protecting individuals from catastrophic care costs and going some way to addressing a commonly perceived unfairness whereby a dementia sufferer will lose all their assets while a cancer sufferer will receive free care.

The proposals also provide a clarity around risk that should allow the development of some insurance and other financial products that will help people pay for the proportion of their care costs.

Nonetheless, the Dilnot recommendations are far from being a panacea, as Stephen Dorrell MP, Chair of the Health Select Committee told the APPG in oral evidence:

"The Dilnot Commission was set up to answer a question that has become increasingly limited when seen against the scale of the challenge that crops up in social care systems."

Most significantly, Dilnot does not answer the question of how to bring more resource into the system, indeed it makes this question more acute.

Notwithstanding this, we believe that serious consideration needs to be given to the Dilnot Commission's recommendations and to the options for funding them. We also need a full debate about the different regional impacts of the recommendations and arguments for and against a localised cap or variable asset disregard limit.

Significant thought will also need to be given to what other measures might encourage a growing market in insurance, annuities and other financial products that help individuals meet a proportion of their own costs.

It is clear, however, that whether or not the Dilnot recommendations are adopted achieving sustainability in the long term will require a systemic re-orientation of the system towards prevention of the sort we have described that can generate efficiency savings and create better outcomes for care recipients.

7 Conclusion

The evidence brought before this Inquiry generates some key new insights. We see, particularly in the evidence from local authorities, that the funding gap in adult social care is significant and getting worse. By 2015 it will become critical for many councils.

While there is an urgent need to bring more funding into the system, this cannot be provided entirely either by the state or by increased individual contributions. Instead we need a partnership model and a redesigning of the system towards prevention.

The scale of the problem may seem daunting, but we believe there are things that can be done immediately to meet some of the challenges we are faced with.

Moreover there are already examples across the country of local authorities and others innovating and developing new practices.

As we have seen, local authorities are already doing great work to reduce demand for care, manage costs, help individuals to stay healthy and to manage their assets more effectively while creating a vibrant market of care provision.

While these new approaches provide grounds for optimism, it remains clear that building a system fit for the future will require a re-orientation of the system towards prevention at a far greater scale than we have yet seen.

We believe we can make significant progress to this goal if we transfer money from acute services to preventative ones to manage that re-allocation and if we give Health and Wellbeing Boards stronger legal powers.

These are not easy choices politically, but we believe the evidence presented to this Inquiry makes a compelling case for them.

Inevitably we have focused on structures and particularly on funding, because we believe that an alignment of funding and objectives is the only way to drive real change and that this needs to be supported by real institutional reform.

We must remember, however, that in the end this is not about government, or money, or processes. It is about millions of elderly people with real needs now and in the future that must be met.

Appendix 1: oral witness sessions

Maria da Silva Chief Operating Officer, Whittington Health

Mark Rogers Group Chief Executive, Circle Housing

Councillor Dr Gareth Barnard Bracknell Forest Council

Anne Higgins Corporate Director of Communities and Wellbeing, Trafford Council

Caroline Abrahams Director of External Affairs, Age UK

Councillor Colin Stears Executive Member for Adult Social Services and Health, London Borough of Sutton

Dr Adi Cooper Strategic Director of Adult Social Services, London Borough of Sutton

Alan Long Executive Director, Mears Group Plc

Stephen Dorrell MP Chair, Health Select Committee

Chris Horlick Managing Director, Care – Partnership

Richard Humphries Senior Fellow, The King's Fund

Sarah Pickup President, ADASS

Cllr Ann Naylor Cabinet Member for Adults, Health and Community Wellbeing, Essex County Council

Shaun Gallagher Director of Social Care Policy, Department of Health

Appendix 2: written evidence

Association of British Insurers
Alzheimer's Society
Barnsley Metropolitan Borough Council
Bath and North East Somerset
Birmingham City Council
Bracknell Forest Borough Council
Brent Social Services
Bridgend County Borough Council
Bristol City Council
BUPA
Calderdale Council
Cambridgeshire County Council
Carers Trust
City of Bradford Metropolitan District Council
Cornwall Council
Derbyshire County Council
Devon County Council
Dorset County Council
Durham County Council
East Riding of Yorkshire Council
Gateshead Council
Halton Borough Council
Hampshire County Council
Haringey Council
London Borough of Havering
Hertfordshire County Council
Home Group
Independent Age
Lancashire County Council
Leeds City Council
Leicester City Council
Leicestershire County Council
Liverpool City Council
Local Government Association
London Borough of Barnet
London Borough of Bromley
London Borough of Ealing
London Borough of Hounslow
London Borough of Newham
London Borough of Sutton
London Councils

Manchester City Council
Mears Group Plc
National AIDS Trust
National Housing Federation
NHS Swindon
North Lincolnshire Council
North Yorkshire County Council
Northumberland County Council
Norwich City Council
Nottinghamshire County Council
Partnership
Prestige Nursing + Care
Royal Borough of Kingston upon Thames
Royal Borough of Windsor & Maidenhead
Sefton Council
Shaping Our Lives
Sheffield City Council
Social Care Institute for Excellence
Society of Later Life Advisers
Staffordshire County Council
Suffolk County Council
Sunderland City Council
Surrey County Council
Swindon Borough Council
The International Guild of Nurses and Carers
The King's Fund
The London Borough of Tower Hamlets
Trafford Council
Tunstall Healthcare
Warwickshire County Council
Wolverhampton City Council
WRVS
York City Council

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The LGiU is an award-winning think-tank

Our mission is to strengthen local democracy to put citizens in control of their own lives, communities and local services. We work with local councils and other public services providers, along with a wider network of public, private, voluntary and community organisations. Through information, innovation and influencing public debate, we help address policy challenges such as demographic, environmental and economic change, improving healthcare and reforming the criminal justice system.

Partnership

Partnership is the fastest growing significant life company in the UK. Partnership is one of the UK's leading providers of financial products for people with health and lifestyle conditions, as well as those suffering from a serious medical impairment. It is expert in the field of medical underwriting and has a unique in-house data set. Partnership was the first company to introduce enhanced annuities in the UK, which offer higher retirement incomes by taking account of people's health and lifestyle conditions. Partnership is the largest provider of Long Term Care annuities in the UK, with 80% of the market. Partnership has been recognised for three years running at the Best Long Term Care Provider at the Health Insurance Awards.

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