



**All Party Parliamentary
Local Government Group**



NEVER TOO LATE FOR LIVING
INQUIRY INTO SERVICES FOR OLDER PEOPLE

Acknowledgements

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The LGiU is an independent and influential think tank with a cross-party local authority membership. Its aim is to strengthen and promote local democracy. For 25 years it has represented the interests of councils and was voted think tank of the year in the Public Affairs Awards 2008.

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Foreword

By Clive Betts MP

**Chair of the All Party Parliamentary Local Government Group
Chair of the Inquiry into Services for Older People**

The All Party Parliamentary Local Government Group has a unique value to offer political debate. We are a genuinely cross-party group, and throughout the inquiry, we have seen time and time again that, when there is disagreement, it is more likely to be between a national and local perspective, or between health and social care, than across party lines. The APPG allows this consensus to happen, even in such a challenging topic as this has been.

The group is also very rooted in the local. Though it is a group in Parliament, it is a group that never forgets its distinctive focus on local government and the issues that preoccupy councils. The APPG provides a valuable forum to bring these issues to the table and debate them from the perspective of our shared concern for the citizen and the needs of localities. The fact that this is one of the largest and most active all party groups in Westminster, with over 100 members, is testimony to the need for this kind of forum.

It has been both a challenge and a privilege to chair this inquiry. I believe in the value that local government brings to local people, and I know from speaking to councils that adult social care is an area where we are simply not delivering what is needed.

This report is making some very strong and clear points:

- public perceptions about ageing need to change — the lives of older people are our lives not their problem
- we need, as a nation, to agree on what we can rely on as we get older and make sure that the outcomes we agree on are publicly known, and that local areas should set out how they will be delivered, led by local authorities
- health and social care need to work much more closely together if services for older people are to improve dramatically — with local authorities eventually taking the lead in joint commissioning
- we need a much more rational approach to preventing ill health in older people and supporting their independence — which means giving priority to a holistic range of services that keep people active and involved in their communities, rather than having to have acute treatment or residential care.

The panel of MPs and Peers for this inquiry was very experienced on this topic, and I am thankful for the commitment and ideas that they shared throughout the process.

Introduction

By Andy Sawford

Chief Executive of the LGiU

“In the same way as we recognise that investing in children and young people will determine the future of our country, we must also recognise that the way in which we treat older people will determine the character of our country in the future. We should also remember that older people are not simply passive recipients of care. They increasingly have the ability to make a massive contribution to their communities and families and to our society. It is incredibly important that we have an adult, mature debate about the issue, which poses one of the greatest challenges that we face.”

Ivan Lewis MP, Health Minister, 5 June 2008

For too long, adult social care and services for older people have been the poor relation of health and children’s services. They are clearly now rising rapidly up the political agenda. The huge response to the APPG inquiry has reflected this.

The inquiry started from the premise that age is not the main determinant of a person or their needs; that by ‘older people’ we are referring to several generations with different histories and perhaps expectations; and that society needs to be sensitive to these diverse aspirations and levels of need. The report is from the perspective of older people as citizens, affected by all public services, and as major contributors to civic and community life.

As would be expected from an all party parliamentary group on local government, the inquiry focused on the key role and contribution of local authorities in promoting the quality of life of older people. The report is about communities and relationships as much as about structures and systems.

Crucially, if the rhetoric around choice, control, dignity and independence is to be translated into reality, policy reform will need to address a wider agenda than social care and health, including housing, leisure, planning and transport. The report stresses throughout the critical role of communities and neighbourhoods in promoting well-being and independence.

Reform has to urgently address and come up with smarter solutions to the complexities of the relationships between agencies and services. It will mean reshaping delivery and access to increase efficiency in the system, to maximise the use of public funding as a whole, and to ensure genuine engagement by communities and older people themselves. It will mean ensuring there is clarity and consensus over what is funded and by whom. It will need to be more explicit about what is cost effective and what are entitlements. It will require an examination of the boundaries between health and social care responsibilities and accountabilities. We hope that the report, informed by a wide variety of contributions, will promote a lively and continuing debate on these complex issues, and we look forward to engaging with you in the future.

Key recommendations

We need:

- **Changed public perceptions**
- **A national agreement of the outcomes that define quality of life in later years**
- **A simple way to know how these outcomes will be delivered in each area**
- **Transparency about what public money is being spent locally**
- **A way to move money from treating illness to preventing it**
- **To broaden the debate about health and social care to address quality of life more widely**
- **A staged process to merge health and social care commissioning**
- **Local and central government to both be responsible for making services more personal**
- **A national gateway to support better housing choices**
- **A simpler way for people to volunteer throughout their lives.**

Recommendation 1

Public perceptions about ageing need to change. The lives of older people need to be thought of as 'our lives', not 'their problem'. Central government should lead this change nationally by tackling the current crisis, which is impeding progress. Local government should lead locally, by providing services which bring people together, particularly across generations. Publicly funded media should support this by raising the profile of the current challenges, opportunities and collective responsibilities surrounding ageing.

Recommendation 2

There should be a national debate on quality of life in later years. From this debate there should emerge a set of outcomes that make clear what we can all expect for our lives as we age. This should be led by central government.

Recommendation 3

Everyone should know how the national outcomes are delivered in their area. Local authorities should have specific responsibility to map out what is available to local people that will provide for quality of life and make sure that there is a simple way for anyone to find out about and access these services. This should apply equally to services available privately, from public services and from voluntary and community organisations.

Recommendation 4

Less money should be spent on costly hospital stays and treatment and more on preventative services, like exercise classes that improve balance and prevent falls. Local authorities who can demonstrate that investment in additional preventative services can reduce costs in the NHS, should be able to have funding transferred from NHS budgets into the Local Area Agreement area based grant.

Recommendation 5

It should be made much clearer to the public what public money is being spent locally on supporting people in later life. Local authorities should be able to use the Sustainable

Communities Act to identify public funds and use this information to petition other organisations to divert funding into services valued by local people, such as post offices and public toilets. Information about local funding should be available alongside information about what services are available locally to meet the national outcomes.

Recommendation 6

The current debate about the future of care and support should not be restricted to health and social care. Central government should commit to looking at older people's services holistically, so that it takes into account all the elements of well-being.

Recommendation 7

People must be able to expect services that are right for them, and not just be given what happens to be available. Local authorities must take responsibility for ensuring that local services can provide for this, and this must be reflected in the mapping and promoting of local services. Central government must take account of this in its funding, and must not make assumptions about large scale contracting if local demand does not allow for this.

Recommendation 8

Health and social care must progressively work more closely if services for older people are to be more flexible, personal and cost-effective. There should be a staged process of integration that starts with pooled funding through the Local Area Agreement. This should include district councils as well as upper tier councils, to reflect the wider dimensions of quality of life for older people beyond health and social care. This should be followed with a piloting of merged commissioning for health and social care, led by the local authority. Pilots could be identified from top-performing local authorities, or from under-performing primary care trusts.

Recommendation 9

As part of the local delivery plan for delivering the national outcomes for older people, local authorities should give a commitment to quality services, and this commitment should be delivered through the development and support of the workforce.

Recommendation 10

More people need to volunteer to support the activities that create quality of life. Using the Year of Volunteering in 2009 as an opportunity, central government should fund local pilots to test different approaches to volunteering, including further development of time banks, formalising or rewarding volunteering, and focused promotions to younger and older people. Pilots should involve people in as wide a diversity of services as possible.

Recommendation 11

It should be easier for older people to move home to free up equity, be closer to grown children or live somewhere that is more accessible. It should also be easier for people to stay in their own homes by adapting them. Planners should see lifelong accessibility as essential to all new building. Local authorities should include help with housing choices as a key element of help available locally, but they should be supported with a national gateway from central government that can help identify specialist housing in other areas and provide tools for testing new developments, finding suppliers, and ideas for better design from the best that is available nationally and internationally.

Chapter 1: Not too late, but getting later

The debate about providing for the lives of older people must happen now — it should have happened already. In this chapter we explore the pressures on the system and the shape of the current debate. It is not too late to act, but we cannot wait much longer.

We are getting older

The future challenges of an ageing society are significant.

The Facts

- Between 2006 and 2031 the UK population will grow from 60.6 million to 71million
- Over 65s will increase from 9.7 million in 2006 to 15.8 million in 2031, from 16 to 22 per cent of the population
- Over 85s will increase from 1.2 million to 3.9 million over that period, yet half will have some form of disability
- The ratio of women to men aged over 90 will fall from 3:1 to 2:1
- 100+s will increase dramatically, but most will have dementia
- Working-age taxpayers will be a smaller proportion of society
- Extended families are more likely to live away; some will lose contact
- Only a tenth of the 1940s generation was childless; a fifth of the 1980s generation will be

Our society is ageing, but not necessarily healthily. By 2031, people over 65 years will show increases in high and moderate care needs by 54 and 53 per cent respectively, with only a 44 per cent increase in those with no care needs. Healthy life expectancy may increasingly have to be the focus for health and social care.

The costs of ageing are rising

In recent years, budget increases for social care have failed to keep pace either with demand, expectations, demographic change, or the rising costs of equipment or staff. For local authorities, increasingly, social care for older people has come to mean whatever this year's budget can be stretched to provide. In 2006/7, while government funding rose by 1.5 per cent, council spending on adult social care rose by 4.5 per cent.

Despite growing recognition of the need to integrate health and social care outcomes, social care remains the poor relation to health in terms of the government's public spending priorities. Between 2002/3 and 2007/8, funding for personal social services rose by 2.7 per cent per annum compared to a 7.2 per cent rise in NHS funding. The Comprehensive Spending Review in October 2007 offered real terms spending increases of 4 per cent a year to the NHS reaching £110 billion by 2010/11. By contrast, local authorities will receive only a 1 per cent increase per annum to provide adult social care. By 2010/11, the number of over 85s will have increased by 7 per cent; a proportionate increase in disability would increase the strain on the social care system. The Local Government Association has estimated that an extra £2.7 billion is needed over the next three years for social care to keep pace with projected demand.

Sir Derek Wanless suggested that care costs would increase from £10 billion in 2002 to £24 billion (from 1.1 to 1.5 per cent of GDP) by 2026. *Our Health, Our Care, Our Say* suggested this would be £31 billion. Some would argue these are modest projections: couple them with declining resources in an era of economic downturn, and a change in the traditional model of service provision and funding is evidently essential. If social care is to achieve more ambitious goals, the proportion of GDP spent would have to

increase to 2 per cent by 2026 — a figure that Treasury projections would only reach by 2054/55. By that time, private contributions would have risen by nearly 50 per cent relative to GDP.

Services are pulling back

Local authorities have improved the amount and quality of social care provided consistently, yet this has been at the high cost of either excluding those who would previously have been supported, or by increasing charges.

Unfortunately, only the rationing of services is universal. Social care entitlements, service provision and charges vary greatly across the country. Three-quarters of local authorities are only able to provide care for older people with critical or substantial needs.

The means testing of social care, just as with pension credit, is often considered intrusive and seen by many to discourage people from planning for their old age and their care needs. Those who do plan, or save more than £21,500, have to pay the full costs of their care. Local authority care is often subsidised, although the maximum charges for services vary from £60 per week to £326 per week.

The current system is very dependent on private and informal care; only 25 per cent of care for older people is local authority funded. Co-payment is already a reality. In the year up to March 2006, personal top-ups to local authority care alone amounted to £1.6 billion. Moreover, 150,000 recipients of domiciliary care and 118,000 recipients of residential care paid a further £4.2 billion for care from their own resources.

Currently, people who need care but are only assessed as have moderate or low needs must either fund their care themselves, rely on informal care from friends or family or, where neither of these options is available to them, do without the care they need. In *The State of Social Care in England 2006-07*, the Commission for Social Care Inspection (CSCI) estimated a shortfall of 1.4 million hours of care to 450,000 older people, leaving 6,000 older people with high level care needs and 275,000 with less intensive needs with no services and no informal care.

Policy steps to date

In January 2006, the government launched *Our Health, Our Care, Our Say*, which outlined seven outcomes for social care: improved health and emotional well-being; improved quality of life; making a positive contribution; increased choice and control; freedom from discrimination and harassment; economic well-being; and maintaining personal dignity and respect.

These outcomes were clarified through *Putting People First* in December 2007, a joint protocol between the government, NHS, LGA, ADASS, CSCI and others. This arguably marks the start of the most radical reform of the sector since the Community Care Act (1990) promising:

- a single community based support system of health and well-being
- partnership between local government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training
- to replace paternalistic, reactive care of variable quality with a mainstream system focused on prevention, early intervention, enablement, and high quality personally tailored services.

Sir Derek Wanless' *Securing Good Care for Older People* (2006) modelled future demand for social care for older people and qualitatively analysed a range of funding models. It advocated a partnership model that promised a minimum universal entitlement paid through taxation with additional personal contributions matched pound for pound by the state. It addressed care needs effectively and removed means testing, offering incentives for people to save for their own future care needs. Other models are emerging, prior to the social care green paper, such as the International Longevity Centre's national care fund, a social insurance based model for sharing risks.

Chapter 2: Thinking differently

There is much that is technical, complex and sector-specific in this report, and in this debate. But just as important are the issues that are very difficult, but are not the domain of the doctor or social worker. They are about our parents, our friends, and ourselves. About our own futures and about the lives of people we love.

And if there is one thing on which everyone agrees, it is that services for older people should show greater humanity.

In the previous chapter, we catalogued the reasons to be concerned about services for older people. But it is essential that we balance the imperative for action with the constant reminder that older people are not a problem. It is a short step from identifying a problem with how we support the older people among us, to identifying the problem as being older people themselves. This we must not do.

Secondly, we must find a way to shift the thinking that says that older people are somehow “other”. Mervyn Eastman from Better Government for Older People put it like this:

“The challenge is that we frequently – including older people themselves – think that older people are somebody else. In a sense, it is about how do we capture and articulate the fact that older people are like everybody else, simply older.”

At the same time, we do not think often enough about the ways that our perspectives may change as we age. In Chapter 8 we look at some of the areas where councils have a role in helping to make the places we live less daunting to people later in life. This may seem paradoxical, but it is not: when we feel a sense of ownership or responsibility, our eyes are open to problems and opportunities. Like a parent of a toddler who suddenly sees the world full of hazards that were invisible before. If we can change our thinking so we identify with older people, their needs will be our concern, and we will naturally remember to take their needs into account.

This is easy to say, and endlessly difficult to achieve. But government can do some things. As Martin Farran from Barnsley Metropolitan Borough Council said:

“At the end of the day, social care is not something that is very high in the general population’s thinking, until they come into contact with it due to a relative becoming ill, due to ageing parents, and so on. However, what people tend to do is to have a distinctly different view of what they want as individuals from what they think they should have for other people. They vote for it and, when you get them to try to think it through, they then say, ‘Well, no, I don’t want it for me’.”

This is the opportunity for both central and local government: we need people to think about ageing more, and we need them to think about it more in relation to themselves. Central government is looking for a new approach to care funding. This is an opportunity to bring people into the debate and start them thinking about their own futures. It is also an opportunity for local government to use the debate to get local people to look differently at local services and start thinking about what they want for their own lives.

Recommendation 1

Public perceptions about ageing need to change. The lives of older people need to be thought of as ‘our lives’, not ‘their problem’. Central government should lead this change nationally by tackling the current crisis which is impeding progress. Local government should lead locally, by providing services which bring people together, particularly across generations. Publicly funded media should support this by raising the profile of the current challenges, opportunities and collective responsibilities surrounding ageing.

Chapter 3: Delivering on a rounded view of living

“Everyone should be valued for their contribution to their community and for the richness and diversity they bring to the city. As we get older our past contribution deserves respect and our future contribution demands opportunity. As our society ages, we must learn from those cultures that consider old age a positive and fulfilling chapter in life, and respect their elders’ dignity.”

Southampton Seniors Council statement on ageing

“Services for older people are not just about social care or health, nor are they about focusing resources for older people on those with the most severe needs. They should promote the well-being of older people by ensuring that universal services are readily engaging older people in the active community with specialist services only when they are needed.”

Dudley Council’s Older People’s Strategy, April 2006

One of our starting places was to ask about the core objectives and key components of services for older people that are designed around the individual. This is not because these have not been identified before, but because they have, and the message does not seem to have been received.

In this chapter we look first at the picture that emerged about the components of quality of life. Then we consider some of the obstacles that currently prevent this rounded picture from being delivered at the local level. We conclude with a view on the national care funding debate, and the linkages to this report.

People in the round

The needs of older people are felt acutely by health and social services. As we have seen earlier, the ageing population is having an overwhelming effect on social care budgets and services. For this reason, it is very difficult to maintain a focus on older people in a way that puts health and social care in perspective. Many older people rely heavily on health and social care services. But many more do not. And the better services are for older people outside health and social care, the less likely it is that expensive care will be required.

The panel was not pre-occupied with the exact definition of the outcomes that define quality of life. What is critical is not the detail, but three things:

- 1) There must be consistency nationally.
- 2) There must be flexibility locally.
- 3) The lives of older people must be seen in the round.

Hearing the views from many sources, the panel identified two key recommendations, set out below:

Recommendation 2

There should be a national debate on quality of life in later years. From this debate there should emerge a set of outcomes that make clear what we can all expect for our lives as we age. This should be led by central government.

Recommendation 3

Everyone should know how the national outcomes are delivered in their area. Local authorities should have specific responsibility to map out what is available to local people that will provide for quality of life and make sure that there is a simple way for anyone to find out about and access these services. This should apply equally to services available privately, from public services and from voluntary and community organisations.

The reason for a national debate is not that the outcomes are likely to be surprising, but rather to achieve understanding by the public, and consensus by government. Outcomes must be public and they must be used — Age Concern supported the vision set out in *Sure Start to Later Life* but was extremely concerned that it “has been allowed to gather dust”.

How they will be used must be up to local government, and central government must not take up the reins. If outcomes are public and recognised, local areas must set out how they will be delivered locally in a way that makes sense for local people. If central government has succeeded in setting expectations nationally, local areas will face expectations from citizens to deliver — this is the best performance management there can be.

National outcomes

It is worth reflecting the message that emerged from the evidence about where help is needed to support a good life. This is not a list of everything anyone needs in life — it is the areas where older people most look for help.

Though the relative priority of each was different depending on the source, each of these areas was frequently reinforced as being critical to living well. We will return to these in Chapter 8 when considering the leadership of the local authority.

A supportive and accessible physical environment: this includes housing that is appropriate, transport and amenities that are accessible and affordable, and public spaces that are welcoming rather than obstructive.

Access to guidance to get the most from life: even in a reformed system, there will be complexities, and older people and their carers need information about what is available, help with difficult decisions and help to navigate the system.

Opportunities to be connected to the community: isolation and disempowerment can be fatal. Like at any age, older people need friends and acquaintances, activities and interests, and to be able to influence public services.

Help with healthcare and the basics of life in a crisis or with a loss of ability: professional services are important, but they have to be suitably linked to the reasons help is needed — an immediate crisis and a long term disability may need different responses.

Prevention

It is not enough to say we will refocus our attention beyond health and social care, there has to be resources to do this. Acute services are very expensive. Services that prevent illness and disability are much less expensive, but the rising costs of services for those in crisis are already unsustainable. As Professor Jon Glasby remarks:

“The difficulty in rebalancing the system is in how to invest genuinely in a preventative long-term agenda while at the same time continuing to meet the needs of people in crisis who come through the front door. If that prevention agenda does not have ring-fenced funding attached to it, does not have a form of double-funding to allow the transition from one regime to a new regime, then I suspect we may set frontline services up to fail.”

Central government is committed to a shift towards prevention. *Our Health, Our Care, Our Say* promised a change in focus from hospital care to preventative services and treatment in community settings. But in 2006/7 the NHS committed only £117 million of its £90 billion budget through local partnerships despite under-spending by £500 million. Moreover, ADASS believes that the NHS’s acute Vital Signs targets undermine moves towards prevention.

There is a financial case for a move to prevention, though it is not an easy one to make. Qualitative analysis has revealed that preventative services of this kind can reduce the costs of acute interventions, and generally have been well received by older people for improving well-being. Nevertheless, there is an absence of robust quantitative research into the cost-effectiveness of preventative services. In some respects, faith in preventative services is dependent on a very limited number of local pilot projects.

Falls prevention provides perhaps the most obvious means to calculate the benefits of investing to save. Professor Alan Walker said: *“About every four or five hours throughout the year, an older person dies as a result of a fall. Help the Aged evidence shows that 2.5 million older people in this country fear going out, because of the danger of a fall.”* And according to Unison, reducing the rate of hospital or care home admissions among older people by 1 per cent could save £3.8 billion a year.

The Facts

The Healthy Communities Collaborative, which aimed to reduce the number of falls and the rate of institutionalisation, revealed significant successes of this form of preventative care. Falls were reduced by 32 per cent and 37 per cent in years one and two respectively through a range of interventions which included the Sloppy Slippers scheme replacing old, ill-fitting footwear and exercise classes. This was estimated to save some £500 million worth of treatment of falls.¹

NOTTINGHAMSHIRE

In Nottinghamshire, Preventative Adaptation Schemes (PAS) equip homes with features such as a grab rail, stair rail or other safety features. “These services have given me peace of mind not just for now but for the future. My wife and I can now move about the house and garden which makes her happy.”

Prevention is not just about falls, with their obvious and direct link to hospital admissions. Prevention is also about providing a holistic range of services that keep people active, happy, mentally alert and connected to others. Good lives are healthy lives. The evidence reinforced this message many times, including the fact that this pattern of health and well-being starts in very early years and continues through life.

These complex interactions are very difficult to use to plan for financial investment. But we need to start somewhere, and providing incentives for local authorities to make the case for investment is a sensible first step, with the caveat provided by Age Concern that:

“Decision makers should not be allowed to shirk difficult decisions about reallocating resources just because evidence with respect to the effectiveness of care and support does not conform to narrow clinical methodologies based only on Randomised Controlled Trials.”

Recommendation 4

Less money should be spent on costly hospital stays and treatment and more on preventative services like exercise classes that improve balance and prevent falls. Local authorities who can demonstrate that investment in additional preventative services can reduce costs in the NHS, should be able to have funding transferred from NHS budgets into the Local Area Agreement area based grant.

Transparency

Creating the means for councils to be pro-active in finding new ways to shift resources into the things that matter for quality of life is critical.

Several submissions referred to councils working with academics to provide robust evidence for strategic planning and investment decisions. Manchester City Council, for example, is a partner, with the University of Keele, in a New Dynamics of Ageing funded project investigating the impact of a number of different interventions on the independence and engagement of older people in four disadvantaged communities in the city. This participatory research will inform future local investment choices.

Many submissions, particularly from voluntary organisations and older people's groups, wanted councils to lead campaigns on local issues, such as the closure of post offices or health facilities, while recognising that local authorities had limited powers, for example, over buses.

Key to empowering councils to act is creating transparency about the public funds being spent in the local area. The Sustainable Communities Act offers an opportunity for councils to look more creatively to find resources that can be diverted into important services.

Recommendation 5

It should be made much clearer to the public what public money is being spent locally on supporting people in later life. Local authorities should be able to use the Sustainable Communities Act to identify public funds and use this information to petition other organisations to divert funding into services valued by local people, such as post offices and public toilets. Information about local funding should be available alongside information about what services are available locally to meet the national outcomes.

The care funding debate

This report is about services for older people, but it is also specifically about the role of local government. With this in mind, we asked for evidence along five specific lines, from the perspective of local government:

- the development of integrated services
- national minimum standards
- core objectives and key components of services designed around the individual
- shifting resources to prevention
- engaging older people in the care system.

Care funding is at the heart of the current crisis, and dominates the national debate; it is important to comment on the relationship between the topics covered here and the future of care funding.

The future of care funding

On 12 May 2008, the government launched a national debate on the future of care funding, which will culminate with a green paper in spring 2009. The proposed green paper will focus on the future funding and structure of adult social care.

The consultation document, *Case for Change: why England needs a new care and support system*, suggests that the principle of sharing costs between the family, the individual and government is the way forward. The challenges then are to find the right balance of contribution, and to support individuals and families in funding their contribution.

Though we did not specifically ask about care funding, many witnesses and submissions still told us they wanted to see a universal element in a reformed system that everyone would be entitled to regardless of income.

We also heard that the variations between councils in the application of the needs threshold, the way the financial criteria is applied and the huge differences in charges are clearly major issues of concern. The

submissions from local government all stress the current crisis in social care funding has driven the pressures on charging and eligibility criteria, and if funding was increased these differences would be reduced significantly.

The key areas we considered in the inquiry had implications for the care funding system.

- *Developing integrated services and refocusing on prevention* will require a major change in the balance of funding between health and social care. The system needs to support, not impede, integration. Shifting resources to prevention is absolutely critical: everyone knows the current system is irrational. Even when money was pouring into the NHS, funding preventative activity was given a much lower priority: with public spending on health slowing down, prevention investment may be seen as a luxury.
- The evidence we received on *the core objectives and key components of services designed around the individual* exposed a lively debate around the future costs of the personalisation agenda. Some of the evidence claimed that personalised services will be cheaper, because they are tailored and will reduce bureaucracy, others argue that experience elsewhere does not support this. We cannot rely on personalisation to bring down costs.
- *Engaging older people in the care system*: Older people are already heavily engaged, as carers and as volunteers. What is needed now is to support people to remain active and independent, to avoid care. People need to engage with services at a fundamental level – to shape services to their needs and to shape outcomes based on their experiences. Designing in participation from the beginning is the best form of targeting.

Broadening the debate

Clearly the financial questions must be resolved as a matter of urgency. But they must not be resolved in a way that perpetuates the current flaws in the system. The recommendations of this report must be read with the understanding that they cannot be achieved without tackling the financial crisis, but also that the financial crisis cannot be solved without a wider vision for services for older people.

In particular, though the crisis is being felt in social care funding, we must define a vision for older people that is not just about social care and health. And financial solutions must reflect that.

Recommendation 6

The current debate about the future of care and support should not be restricted to health and social care. Central government should commit to looking at older people's services holistically, so that it takes into account all the elements of well-being.

Chapter 4: Services shaped for people

“Our vision within Barnsley is to have people maximise their aspirations for control and independence over their health and well-being supported by flexible, responsive, preventative services.”

Barnsley Council Every Adult Matters

If we are starting from a perspective of a more human approach to later life in the round, we equally need to continue to develop a more human approach to social care. A large percentage of the submissions addressed the change to a more personalised approach to social care, with self-directed support and individual budgets.

The submissions were largely supportive of the changes in approach, the principles behind it and of the system-wide transformation that is required to deliver it. However, there were many concerns about how change will be implemented.

The vision

What is the vision for personalisation that our witnesses and written evidence expressed?

Witnesses saw the transformation to a personalised approach as being a move from paternalistic services to a person centred one. As Professor Jon Glasby put it:

“We have a 1940 system with 1940s aspirations and assumptions that we are trying to work with in the early 21st century. We are still trying to work with a generation of older people on the basis of the gift relationship at a time when in the rest of society and, indeed, in other welfare services we are moving towards much more active and informed people who are much more citizens and consumers rather than passive recipients of services, and where we have much greater expectations around citizenship and entitlement”.

Witnesses stressed that individual budgets do not equate to personalised and self-directed support — they are a tool of them. Personalisation is about a major shift in responsibilities and power, with profound implications for professionals and providers, as well as for users.

Individual budgets

Individual budgets bring together the funding a person would receive through a social care package after assessment and up to five other funding sources, such as supporting people. People receive a funding statement and are able to make choices about the support and services they need.

The evidence from the 13 pilots run by In Control is of high levels of satisfaction. The majority said they had a better quality of life as a result, and had greater choice and control over the services they needed.

The panel heard from West Sussex, Barnsley and Manchester City Council who were pilots, and each council reported major successes. Cumbria County Council, though not a pilot, has used individual budgets extensively and also provided witnesses at an oral evidence session.

Simon Duffy, Chief Executive of In Control, described what having an individual budget can mean:

“You can give people control of it and you can also give people the right to control how much control they have over it. That might seem a funny point, but it is also important. People do not always want complete control but they want some control; also, and very importantly, the right to spend that money on services that really make sense.”

CUMBRIA

Perhaps I could give you an example of an older person — and this is somebody we failed in Cumbria — who was a hill-walker (as a lot of people are who come and live in Cumbria) and who had dementia. What we offered him was day care. He went there, sat down all day, and after three months he was dead. When I went to the Alzheimer’s Disease Society and talked to them about offering choice for people, his wife came up to me and said: “I wish that you could have done that for my husband, because what he wanted was somebody who would go on the fells and walk with him.” She could not do it, but that is the kind of respite they wanted. With an individualised budget he could have had that, and what we offered him was a standard service. That is the change we want to make. He may not have been able to articulate that, but the person dearest to him could have articulated that for him and he could have been walking in the fells.

Key issues raised about moving to universal individual budgets

Future costs

There were different views expressed about the future costs of moving to a personalised system, with individual budgets becoming the norm.

Councillor Gareth Barnard from the LGA, speaking in favour of personalisation, stressed the need for more resources because “the personalisation agenda is no less expensive than some of the traditional social care models”. Unison referred to an international study by the Social Care Institute for Excellence (SCIE) of similar schemes which found that “virtually every analogous scheme in the EU has been based on an underestimate of costs, at least partly due to unpredicted demand and unmet need”.

A Demos report showed that in 10 local authorities, personal budgets had cost about 10 per cent less than comparable traditional services. However, this is an average — in four out of the 10 local authorities evaluated, costs were higher under the personal budget arrangement than they were under traditional services.

There is an expectation that individual budgets will lead to a move away from more costly residential care, and that the system will be more efficient, better targeted and less bureaucratic. Although these assumptions are undoubtedly largely correct, nearly every submission emphasised the need for new kinds of support and advocacy.

Professor Beresford called for “*a real infrastructure of support to enable the wide range of older people to be able to benefit from it, so that choice can be meaningful rather than just a glib piece of rhetoric. That means information; it means advocacy; it means advice; it means guidance; and it will have its own cost implications*”.

SOUTHEND

Southend Council is exploring the potential of developing ‘brokers’ for mainstream services who will look at an individuals needs and what they want to do, source or identify possible options and help the person to access them — for example if you like to go on countryside walks, the broker would identify where you could do this in your community, what transport there is to get you there, how much it would cost, if there are any subsidies, and help you make arrangements to participate.

Local authorities and service providers like The UK Homecare Association (UKCA) also talked about the cost implications of moving from block contracts to more customised support packages.

Transition

There was concern expressed in many submissions that the move to individual budgets would become target driven. Simon Duffy pointed out that it has been a slow process and the speed of implementation is hardly a concern. The UKCA said that there were no policy signals to the sector on how quickly the transition is intended either nationally or in each locality.

There were concerns from academic witnesses that the evidence base for individual budgets was not robust enough. Experiences from abroad all point to major difficulties in transforming how the system works. Personalisation and the widespread use of individual budgets require significant changes in funding, culture and, indeed, the nature of organisations. The consensus view was that moving from pilots to a universal roll out will be highly complex, needs thorough evaluation and careful management, and should be gradual. Less ambiguous direction on this issue is needed from the government.

Witnesses were concerned about sustaining services during a transition period and beyond. If many people, for example, choose not to use day care, centres are bound to close. There were mixed views here — some witnesses felt day care was not popular or usually a quality service. Others felt many people would suffer if facilities they relied on were to shut down.

Unison wanted a more imaginative approach:

“Before we rush to close them down, however, we feel that we need to have an agenda that is about building up, interchanging, adapting and evolving some of the services that exist – taking the whole workforce along with the idea of providing personalised support”.

Professor Alan Walker, again supporting the personalisation principle, said that, nevertheless: *“there is the danger of a caricature – of welfare services that do not change or are inflexible and no one wants them – which is absolutely nonsense. There is so much good evidence of high-quality provision around. Then the alternative is a complete free-for-all ‘personalised budgets is the answer’. It cannot be a one-club solution”.*

Older people’s organisations made similar points including Blackburn with Darwen Older People’s Forum, which said: *“It also needs to be recognised that for some people an externally organised and delivered care service will still be the most appropriate and this option should not be removed.”*

Age Concern stressed that bringing in individual budgets has to be done right and in a managed way — it was particularly concerned about emerging age discrimination in personalisation, with very different budgets being allocated to different age groups.

Risks and regulation in a personalised system

There is a general view that a more personalised system will have to be less risk averse:

“Certainly, through the individual budget pilot sites we have found that, when you tap into older people’s experience, they come up with creative solutions that we would never have thought of. They help us to get round the issues about how to manage risk, because actually, as social work professionals, we are risk-averse. In terms of doing that, we have to tap into releasing some of the controls that we have.”

Martin Farran, Barnsley

We asked in the call for evidence whether there should be national minimum standards in every area of adult social care. The majority of submissions wanted to see the principle extended to new areas, excluding informal care. But what is the right balance between the need to protect individuals (and workers) and to not over-regulate a system that is based on individual choices, particularly in relation to personal assistants? Kensington and Chelsea refers to “the best care possible” rather than enforcing standards of care.

Age Concern suggests that the move to self directed support means that standards may need to be defined in terms of outcomes rather than outputs, and will need to be flexible enough to embrace different preferences and needs.

Many submissions want to see achieving dignity in care being given the highest priority, and, like Age Concern, a focus on softer outcomes, with users and carers being asked whether services improved their quality of life. However, as Southend Council says, categorising new areas would not be simple, particularly given the flexibility which is built into the opportunities for self-directed care and the direction of the future role of the local authority in adult social care.

“The transformation agenda will enable people to purchase their own care. One of our concerns is that this may entail moving from a regulated home care market to a deregulated home care market. We feel that this issue needs to be clarified within the context of the individuals own responsibility.”

Hackney Council

Unison and other submissions wanted to see regulation of the new providers that will be coming into the market to provide employment and advice services. Norfolk County Council felt that councils should be encouraged to develop a wider consumer protection role for people purchasing or arranging their own care.

Conclusions

Managing support for individuals and managing markets will be increasingly key local authority roles. New markets will grow and some providers will find it hard to compete. Submissions stressed that councils should be supporting good quality, specialist providers to adapt to the changing context. There will remain the need for strong care management.

ADASS emphasised that it is *“a strong exponent of the personalisation agenda, but at the same time we do not believe that it is a panacea at all. Indeed, some of the earlier information we are getting from the 13 pilots seems to indicate that in terms of some of the systems, while it might benefit some individuals it does not benefit all of them”*.

The British Society of Gerontology felt the transformation agenda did not adequately address the situation of the current and future huge numbers of frail elderly people who will need the kind of safe environment that residential care can provide. Many submissions make similar points — that one model does not fit all — that individual budgets, for example, may not be the most appropriate model for some highly vulnerable people.

Professor Walker emphasised the dangers of “the people with quiet voices” being left out — those with dementia or with severe learning difficulties: “We have to ensure that quality standards, access and fairness are maintained so that their voices are heard alongside those who can demand what they want.”

Aberdeenshire Council’s submission highlighted that these questions are as relevant to Scotland as to England:

“Direct payments and individual budgets have an important role to play, but are not appropriate or suitable for every service user. There are issues about the monitoring and use of individual budgets by older people who are very frail, vulnerable, cognitively impaired, or at risk of abuse and in need of protection.

“Services must be able to be provided flexibly, and innovative forms of service delivery are required. This is a challenge for local authorities who are required to demonstrate best value, cost-effectiveness, and deliver within budget; there is a tension between these requirements, equity of service provision, and personalised design and delivery of services.”

There are outstanding issues around how the budgets will be calculated, whether they will be set in stone or whether they will be portable. The very complex questions around eligibility and assessment do not go away with a more personalised system. The differences in culture between the NHS and social care can still undermine the principles behind personalisation.

The green paper on social care needs to address the contradictions in this agenda — a sustainable settlement around future funding and the breaking down of barriers between health and social care are essential ingredients if there is to be genuine transformation to a person-centred and flexible system.

Recommendation 7

People must be able to expect services that are right for them, and not just be given what happens to be available. Local authorities must take responsibility for ensuring that local services can provide for this, and this must be reflected in the mapping and promoting of local services. Central government must take account of this in its funding, and must not make assumptions about large scale contracting if local demand does not allow for this.

Chapter 5: Services shaped for sense

Towards integration

The case for joining up services is crystal clear, so that older people, often with complex needs, do not have to negotiate through a confusing multi-agency system. Turning the aspiration into reality is, however, slow and difficult.

Despite this, there are a large number of impressive examples from the submissions, and from the oral evidence sessions, of joint working between social care and health at the local level (there are far too many to list).

This can take the form of strategic integration — with joint planning and possibly pooled budgets — structural integration, where there is common governance (such as in Care Trusts), and integration around delivery, with, for example, multidisciplinary teams. A clear sign of growing integration is that around half of all Directors of Public Health are now joint local authority and PCT appointments.

KNOWSLEY

In Knowsley we have made significant progress in service integration, between the council and the PCT. The Chief Executive of the PCT is also Executive Director for Health and Social Care in the council. The jointly appointed Director of Public Health has been in post for over four years. Integrated management arrangements are in place between service provision in the PCT, and social care services for older people, with managers increasingly managing a mix of staff from health and social care.

Many teams are co-located, and there are a number of integrated teams, including urgent response services, intermediate care, and early stroke discharge. There are effective secondment arrangements that allow staff to move between organisations, while protecting their length of service benefits, and this has been used not just between the Council and PCT, but also for specialist NHS services, and with the Fire Services Authority.

This has supported the breaking down of professional and skill barriers, increased staff retention, and enabled different roles to be developed, for example generic health and social care workers, undertaking both health and social care tasks.

Submissions highlighted many different approaches to joint working and service integration. These need proper evaluation to establish what is working well.

Although there have been legislative changes over the last decade to facilitate integration, such as the flexibilities introduced in the 1999 Health Act, there are still serious obstacles in place. The establishment of Care Trusts has been slow and usually rather limited in what they cover, for example concentrating on particular client groups.

We received evidence of more fully integrated models from Torbay Care Trust and Peterborough Council where the organisations point to major success in achieving positive results for their local communities. Most areas have not gone this far, but are developing a more gradual approach, backed up by the new Joint Strategic Needs Assessments and Local Area Agreements.

PETERBOROUGH

Peterborough City Council has fully integrated health and social care services, including the responsibility for the commissioning, contracting, delivery and performance management of adult social care services. They chose to merge the PCT with social care while retaining the organisational status of a Primary Care Trust. From 1 April 2008, the PCT Board and PCC Cabinet agreed that the provider arm should become an Arm's Length Trading Organisation (ALTO) providing the statutory duties of adult social care and all community health services for adults in Peterborough.

Government funded initiatives like LinkAge Plus and the Partnerships for Older People Pilots have certainly been successful, though Age Concern claim that the programmes have been better at establishing new services than re-designing and integrating existing ones.

ADASS, however, points to successes particularly where integration has focused on those people at greatest risk of losing their independence because of a critical event which could have led to their admission to hospital or permanent residential or nursing home care. *“There are many examples around the country of excellent ‘intermediate care’ services that demonstrate the realisation of the potential effectiveness of integrated approaches for people facing such critical points in their lives.”*

Where integration is lacking

However, the evidence shows the picture is rather fragmented — with different levels of joint working within an authority, perhaps around a particular client group. Progress is being made incrementally where relationships were already established. Many submissions said that effective joint working was patchy:

“As with many areas of local government, what has tended to happen over recent years is that good authorities have become better at joining up their services, while others are still on the starting blocks. Emerging findings from the Audit Commission’s inquiry into older people’s services suggest that around a quarter of local authorities are in the latter position.”

Help the Aged

Several submissions point to the lack of joined up thinking at the centre. London Borough of Kensington and Chelsea, for example, say that *A Sure Start to Later Life*, has only been implemented in a limited way, through, for example, LinkAgePlus pilots. Policies for older people are insufficiently joined up at a national level, with the Department of Health exploring prevention and early intervention apparently in parallel with the Department of Work and Pension’s Opportunity Age programme, while the Cabinet Office which leads on social exclusion is not considering older people.

Stronger leadership and coordination is needed. In particular, no one in government has ‘joined the dots’ between the social exclusion and ill-health prevention agendas.

Barriers

“Objectives for PCTs and local authorities are managed through different performance management systems and monitoring against objectives is done differently. There are different agendas, different targets and different accountability. It is clear that in many areas PCTs want to co-operate but their priorities are affected by national priorities set by the Department for Health.”

County Councils Network

Although there is a clear desire from health and social care to work much more closely together, there are very real difficulties, with different legal and financial systems and diverse cultures.

BUCKINGHAMSHIRE

There is a Joint Director of Public Health who is leading on the development of a Healthier Communities Strategy. This considers all health determinants including community, education, transport and leisure as well as health and social care services. There are two joint appointments with the PCT, a planning and commissioning manager for older people and a service development manager dedicated to services for older people with mental health needs. Future plans include integrating teams and pooled budgets but only where there is evidence this will make a positive difference to older citizens in the county. A tremendous amount of energy goes into integrating staff from different organisations and this can dominate thinking and performance to the detriment of the delivery of the service to those we are here to serve.

Other frequently cited practical obstacles are different information requirements and systems, and issues around privacy and sharing information. The frequent structural changes in the NHS have meant it has been hard to build up relationships and PCTs often do not have the capacity to move at the pace of the partnership agenda.

The BMA and Unite refer to the increasing fragmentation of delivery in the NHS and claim that this makes joint working harder to achieve.

Much greater strategic level service integration is difficult without addressing the differences between health care being free at the point of delivery and social care increasingly subject to means testing. It is very difficult to achieve seamless service delivery to people, particularly those with continuing care needs, and cost shunting is still happening according to witnesses at the oral evidence sessions.

Many submissions stressed the need for major cultural shift:

“A cultural shift is also needed to support new and flexible ways of working and joint problem solving. This will lead to an understanding of the pressures under which all parts of the system work and an ability to have local discussions around sensitive issues such as the quality, location and balance of services.”

“The commissioner/provider relationship within the NHS also needs to be rebalanced to allow this to happen. Some of the perverse incentives within the current systems of payment by results, practice based commissioning and separate systems of health and social care need to be taken into consideration and processes realigned with the flow of services.”

LGA

Local government organisations and individual councils stress the difficulties of establishing relationships with foundation trusts:

“Many counties continue to have concerns about the accountability and priorities of foundation trusts. For example, foundation trust business plans are built on the health of the trust, rather than on the needs and interests of the community. This may mean that the trusts focus less on local partnerships and user groups outside their own community membership scheme, and links to the Local Strategic Partnership and Local Area Agreement may not be sufficiently strong to deliver on partnership working.”

County Councils Network

There are contradictory messages from the government as well — foundation trusts are meant to perform in an increasingly competitive environment which may not be compatible with cooperation.

Lancashire County Council said that pooled budgets were a valuable way of achieving seamless provision *“provided governance and accountability are clearly defined and the budgets pooled are fit for purpose”*. However, pressures on continuing care budgets locally meant that decision making around how the new

funding linked to the launch of the new DH Framework was not always shared: *“this is an example of how agencies pull back from partnership working; when the resources are scarce there is a tendency to go back to core business”*.

Ingredients for success

Partners agreeing a shared value base at the outset is seen as fundamental, as well as strong leadership at local, regional and central government levels and commitment and sign up at all levels across all organisations.

“Integrated services can only be achieved based on common objectives and outcomes, robust joint commissioning plans based on joint strategic needs assessments that evidence the added benefits of integration, and strong local leadership, ownership and adequate resources from all stakeholders.”

ADASS

Sustainable community strategies and LAAs can be effective vehicles to establish shared objectives, and then to ensure that robust joint commissioning strategies are in place which identify the service areas where outcomes could be improved through integration. There is some concern from outside local government that the recent round of LAA negotiations were hurried, and may only drive improved integration of services where this was already in train under the previous regime.

Councillor Barnard from the LGA stressed at the third oral evidence session that the new Comprehensive Area Assessments need to make judgments on level terms about the duty of the partnership, and the cooperation between the NHS and local government in achieving objectives:

“Up to now it has been the case that you can have a high performing trust that actually focuses on their targets, some of which are fairly narrow, where actually the partnership work is not explored to the (same) extent. So you can end up with a three star trust but a two star local authority, because of the issues around partnership working. Once there is consistency in terms of audit inspection across all the partners where the equal balance and judgment is given to partnership working in actually delivering outcomes together I think that will focus the mind.”

Some councils, such as Lancashire County Council, Bournemouth and North Shields wanted a more prescriptive national steer on how integration can take place at organisational level.

Beyond health and social care

A strong message from the majority of submissions and from witnesses at the oral evidence sessions was that health and social care cannot deliver the holistic vision of *Our Health, Our Care, Our Say* on their own. Quality of life and well-being are determined by wider issues, such as housing and transport. There are also the highly complex issues around benefits — these are outside the scope of this inquiry, but we recognise that integration will need to involve benefit and welfare systems to be effective.

The way forward

The evidence suggested three things.

First, that there is a clear direction of travel towards much closer working between local authorities and health, not just in partnership but in blurring the boundaries between organisations. This must be right: nowhere did we find a convincing argument in terms of the lives of people that justifies a sharp distinction between health and social care. The only clear distinction is about what is free and what is paid for — but this cannot be fundamental when the issue of funding is so very clearly in question.

Second, that lessons are being learnt through trial and error. Local partnerships have been scarred by wholesale national reorganisations. But quiet experimentation is driving innovation.

Third, that there are key tools which are supporting integration: Local Area Agreements, Joint Strategic Needs Assessments, joint commissioning, joint appointments.

With these in mind, the panel is clear that integration should move from being patchy and struggling to being deliberate and planned. Organisational boundaries between local authorities and primary care trusts should be dismantled, leading to the merger of commissioning, led by the local authority. Taking into account everything we have heard about the holistic needs of older people (see Chapter 3) it is only the local authority that can co-ordinate services across the spectrum of need. And given the clear need for difficult decisions about resources, now and in the future, there has to be a strong democratic input into them.

BUCKINGHAMSHIRE

Effective local democracy is vital to the country — elections across the world in the last few months have shown that democracy cannot be taken for granted and needs to be nurtured and further developed. While there are non-executives on health boards they do not have the same power or influence as locally elected members. To truly ensure the rights of a vast section of our population resources focused on older people should be allocated through local government. Practice based commissioning is seen as a way to ensure a local response to need: it would be interesting to see what happened if local authorities were resourced and authorised to mould healthcare.

For this to be successful, it should be staged and based on ongoing evaluation. It should also build carefully on the partnership working that is already in place. Pilots should aim to develop a model that offers a transition plan for integration, from joint planning to full shared commissioning. Much of this could be started from experiments already under way, such as Torbay and Peterborough.

Recommendation 8

Health and social care must progressively work more closely if services for older people are to be more flexible, personal and cost-effective. There should be a staged process of integration that starts with pooled funding through the Local Area Agreement. This should include district councils as well as upper tier councils, to reflect the wider dimensions of quality of life for older people beyond health and social care. This should be followed with a piloting of merged commissioning for health and social care, led by the local authority. Pilots could be identified from top-performing local authorities, or from under-performing primary care trusts.

Chapter 6: Services need people

Services for older people are supported by a vast and complex network of people, mostly low paid staff or unpaid carers and volunteers. If we want better services, then we cannot ignore the people who provide them.

The workforce

There are 18,570 residential homes catering for 420,000 older people. 4,700 domiciliary care agencies deliver 4.5 million hours of care to 440,000 older people. Above all, the formal social care system depends on the skills and application of its workforce. The workforce accounts for 80 per cent of all social care expenditure. In the UK, there are 957,000 care workers providing formal care to older people: 635,000 in residential homes and 322,000 employed by domiciliary agencies. 83 per cent are women. 50.4 per cent work part time.

Care workers are employed in a variety of public, private and voluntary sector settings. Social care is, as a result, not as uniform and nationally organised as education or health. Therefore, it is difficult to establish common frameworks that will support the whole care workforce.

The All Party Parliamentary Social Care Group undertook an inquiry which saw low pay, lack of training and the low morale and status of the sector as the main problems to be addressed. This inquiry echoes the vision of the 2020 workforce set out in the Options for Excellence report (October 2006); namely, a workforce that is highly skilled, valued and accountable, provided through continuing professional development, improved workforce planning and workload management.

Recruitment and retention of staff is a significant problem that undermines the quality and consistency of care and increases the transaction and training costs for providers. Since 2003, the number of care worker vacancies has remained above 75,000. There is a high staff turnover, which averaged around 12 per cent between 2001 and 2005 and has peaked at 25 per cent in the last year, although there are local variations in supply.

Improving health and social care workforce capacity and skills emerged as common concerns in many submissions. The government trebled spending on workforce development and training between 2002/3 and 2005/6 to £284 million. Although the number of NVQs has been rising, up nearly 43 per cent in the year to June 2006, the majority of social care staff is unqualified.

Furthermore, it was suggested that personal care and listening skills may be just as important as technical/medical skills to older people.

Personalisation

Personalisation will have a significant impact on the formal workforce and on unpaid carers, who may be employed as personal assistants by personal budget holders. Service users and carers will have a greater say in how the workforce is deployed and trained. As a result, monitoring and scrutiny should increasingly be decentralised to local partnerships. While safeguarding vulnerable people is an important issue through CRB and other checks, and national registration schemes, a delicate balance will have to be struck to ensure that risk management is balanced against excessive costs and unnecessary bureaucracy for service users and care staff alike.

Personalisation will undoubtedly make the care market and its workforce more atomised and difficult to regulate. The issues of who employs who and what services are available will require novel solutions. Flexibility and innovation is the key to ensuring that the workforce and the services they provide are geared to individual needs. While care workers may increasingly be expected to carry the risk in a

personalised system of social care, particularly if self-employed, local authorities and local partnerships will have to ensure that the care market and its workforce are sustainable in the new system. Securing the supply of qualified staff is vital to the future of social care. More effort should be made by local partnerships to provide training, and the government needs to communicate a better vision of the careers that are available in the sector.

Informal care

Health Secretary Alan Johnson launched the government's carers strategy as follows:

"To say that carers are unsung heroes and heroines is without doubt an understatement. They do an amazing job and deserve our respect, our understanding and our support. This new strategy is another big step forward, and has the commitment of seven government departments, carers and those who work with them. It is broader than health, looking also at housing, benefits and education."

From 2008-2011, the new carers strategy will invest over £255 million in new commitments in addition to £22 million previously committed. New commitments in the strategy include:

- £150 million towards planned short breaks for carers
- £38 million towards supporting carers to enter or re-enter the job market
- £6 million towards improving support for young carers.

Nevertheless, the strategy leaves much work to be done post 2011, particularly with regard to benefits and mainstream entitlements. In the meantime, local authorities and the DWP could offer carers a free benefits check, supported by Carers UK and Princess Royal Trust for Carers.

According to the DWP, approximately 465,000 people receive the carer's allowance. Carers allowance is currently paid at a rate of £48.35 per week to those who earn less than £95 per week.

The take up of carers' benefits is far too low. The complexity of the benefits system nationally and locally does not help carers. In addition to carer's allowance and premiums, carers could be entitled to disability living allowance, attendance allowance, pension credit, housing and council tax benefits, incapacity benefit, and income support.

The Facts

- The Princess Royal Trust for Carers helps carers to access several hundred thousand pounds in unclaimed benefits every year.
- At one event in 2007, a benefits specialist saw 77 carers identifying £151,476 of unclaimed benefits for those carers (about £2,000 per carer per year)
- The Carers Resource in Harrogate averages unclaimed benefits identification of over £1 million per annum

A simplification of the benefits system would help to demystify entitlements for carers and care recipients. The new settlement should reflect the social value of caring. The new system of social care will need to consider not only the needs of older people who are being cared for, but also the needs of older carers and caring families themselves. Carers are often disadvantaged in respect of health, income and employment opportunities — disadvantages which endure beyond their caring responsibilities.

The coordination of seamless support for unpaid carers across central and local government is impeded by the absence of a national registration system for carers and by ineffective communication and outreach to carers in need. An added complication, according to Carers UK², is that 65 per cent of people with a caring responsibility did not identify themselves as a carer in the first year of caring. For a third of them (32 per cent) it took over five years before they recognised they were a carer.

The value of informal care

Currently, informal care is plugging the gaps in social care provision. Informal carers play a vital role in allowing 1.9 million older people to continue to live in their own homes, providing 65 per cent of care to older people. The value of their contribution has been estimated to save the exchequer some £61 billion per annum.

The ageing demographic will result in increased demand for unpaid carers. Carers UK has calculated that the number of carers will need to increase by three million by 2037³ if we are to care for our ageing population. Were the supply of unpaid care to fall by 10 per cent, state provided care would need to increase by over a quarter to plug the gap.

In a few decades, people will reach old age with fewer children than today, their families will live further away, and more will live alone. This trend is highlighted in research by Linda Pickard into those who will provide intense informal care (20 hours or more per week). From 2005 to 2041, the care-receivers to care-providers ratio will fall from 0.6 to 0.4, leaving a quarter of a million disabled older people without intense informal care. In 2005, 90 per cent of intense formal carers of parents were of working age. By 2041 that number will have to double to keep pace with demand.⁴

Analysis of the opportunity cost of informal care, which includes the loss of earnings from paid work that carers forego when looking after someone, reveals some interesting findings. Indicative projections by the IPPR⁵ suggest that, in 2001, those of working age who were economically inactive and provided intensive unpaid care lost a potential £5.47 billion in income — almost three quarters of the estimated costs of substituting that care with formal care services. Ongoing research by Linda Pickard is analysing the cost/benefit of substituting 20 hours of informal care with five hours of formal care. If proven, this could have profound implications on public policy decisions.

Given the demographic changes post 2045, the system may not be able to depend on informal care within the family. As a result, society will have to invest more in formal care.

Volunteering

Although many older people volunteer in the community, the peak period for volunteering is between the ages of 45 and 64.

Local authorities are perfectly placed to help to coordinate volunteering through the development of time banks, encouraging local philanthropy, negotiating with businesses to provide expertise or staff on half day release, or encouraging schools to deliver support to older people in the community as part of the citizenship curriculum.

“It is worth noting that the voluntary sector, such as Age Concern Hertfordshire, which is predominantly funded by Hertfordshire County Council and supports 3,000 older people per week, has a specific and positive focus on promoting well-being as well as its remit for prevention and early intervention. It also makes extensive use of volunteers and more than 300 of these are over 50s.”

Stevenage Borough Council

Clare Rayner, President, Patients’ Association stated: *“With very little effort local councils could collect a vast body of volunteers who would be more than pleased to have something worthwhile to do with their time now they have been made redundant or have retired long before they wanted to. Social days for company, for taking people out, doing their shopping.”*

We asked in the call for evidence for examples of the contribution older people make in their communities. The response was sometimes angry — how could the panel not recognise the huge contribution older people make — they vote more than anyone else, are the most active volunteers,

provide support for grandchildren, run parishes, are councillors, social entrepreneurs and many still work. Of course, this was recognised, but the panel wanted a feel for what was happening locally. The problem is that these activities are undervalued by society — as people said in our seminar, older people are valued by individuals and by organisations for their contribution, but not by society itself. Again, councils have a role to play here — by highlighting how communities rely on older people and by supporting people to take up challenges in later life.

The inquiry also asked if the voluntary activity of older people should be recognised in more formal ways. The response was largely negative — formalising it would put people off. However, there was some support:

“We are keen to explore opportunities in Hampshire that would allow older people who volunteer to get something back (in the form of a contribution towards leisure, adult learning, care, or other council services) and would be interested in how this theme of your inquiry develops.”

Hampshire County Council

Help the Aged says that time banking has become popular in some areas. Time banking would give recognition and something in return to volunteers. Councils could play a larger role in being an intermediary and perhaps putting some capital up front.

The voluntary sector

The voluntary sector offers a wide range of services to older people including advice, support, advocacy and policy development. Many social enterprises have been established to provide more responsive and specialist care services.

All political parties believe that the voluntary sector has an important role to play in social care delivery. The evidence from voluntary sector organisations is that their activities should never be a substitute for public service provision.

The eight largest care home suppliers, with 20 per cent of the market, offer as many care places as local authorities and the voluntary sector combined. Although the private sector is the key player in residential and domiciliary care, the voluntary sector offers 59,000 places out of 441,000 in its 3,437 residential homes. It has less emphasis on domiciliary care, where private sector agencies dominate the market.

Deliberations on the future contribution of the NHS to social care should consider the limited role it plays in the care market today. For example, it offers only 1,500 residential care places — less than a third of one per cent of the market. Indeed, even traditional NHS services will be more open to competition.

The private and voluntary sectors will play a bigger role in the provision of community services and primary care, according to NHS Chief Executive David Nicholson. In particular, “we will see more services provided by the independent sector as part of this, where they can provide value for money and can do it better”. (*Financial Times*, 25/06/08)

“The role of the third sector is of great importance in providing services to older people but it needs better funding and promotion. The third sector would bring the ability to better join up services to provide a more integrated experience. For example community transport linked to lunch clubs as opposed to the in house provision of Meals on Wheels. Getting those able and willing to do so to leave their homes on a regular basis increases social mix and promotes inclusion, thereby enabling relationships to develop that would lead to increased mutual support and improved general well-being for older people.”

Tendring District Council

First Connect

First Connect — a voluntary sector service in four pilot areas — is targeting low-level needs for example: befriending, aids, adaptations, advice on benefits and other services (public and private), helping people to negotiate through the web of local service options, and can cover over the cracks in the current system. Schemes include:

- in Leeds, neighbourhood networks of older people help each other to achieve/maintain a good quality of life
- footcare service in Cambridgeshire
- Pershore older peoples entertainment therapy service.

CUMBRIA

“We have been working with Better Government for Older People, and with In Control, to reform our older people’s services, moving much earlier to prevention. Not prevention services that are run by the council but prevention services that are run by the third sector, which are based on real evidence of what works; working with sustainable communities to make sure that older people can stay connected with their communities and have their services locally.”

Cumbria County Council

“We try to use volunteers to support people in their own communities... a kind of active befriending scheme, for want of a better term. The reason we do that partly is because we have a very successful Supporting People Floating Scheme, which is about helping people move if they need to. Even if you want to move in your own community, the actual packing up and moving can be so traumatic that you never settle in your new place. It is using that as a reminiscence opportunity; an opportunity to buddy somebody; and then, when that person moves house, to go and unpack, sort it out, and maybe then have to get rid of things because of downsizing; to take you to the church for the first time, to bingo, or whatever you want to do, out to the local pub – whatever it is so that you become connected into that community.”

Age Concern Cumbria

Conclusions

It is ironic that of all public services it is care, now notorious for budget overspends, that perhaps appears most dependent on the contributions of the very low paid and those who are not paid at all. There are many things that could be done to improve the lives of the people employed in supporting older people. Issues such as benefits and employment rights are the remit of central government and therefore are not the focus of this inquiry.

Within local government’s gift, however, are two key issues. These were summed up in the experience of an anonymous contributor who faced, among other issues, low standards from paid care workers, and unreliability from volunteers. The stress of such difficulties should not be underestimated. Many carers will recognise the painful sentiment:

“I would strongly advise anyone not to take on the care of elderly relatives. The destruction of the carer’s life can be total and devastating.”

First, there must be a systematic approach to raising the status and skills of care workers. With such stretched resources in the system, it seems a luxury to invest in quality, but any hope of providing quality of life in later years rests on care being delivered well: with professionalism, high standards and humanity. The quality of care should be integrated into the way local authorities consider prevention and well-being — as a necessary component of quality of life. Warrington Council has been able to inspect

local care providers and services to improve the dignity of care services in the borough. The result has been a marked improvement in local care provision — proof positive that local place shaping can be just as effective in improving standards as national inspections.

Second, there should be a re-assessment of the role of volunteers. There is both a deep suspicion and a heady enthusiasm for volunteering. Many suspect the use of volunteers to be an inadequate replacement for properly funded services. But there are also excellent examples of services provided by volunteers that would not be done by professionals. Moreover, both the government and opposition have recently made announcements about promoting volunteering.

What seems most obvious is that there is little good evidence about what increases volunteering and what the necessary conditions are for it to be sustainable, of high quality, reliable and economic.

Recommendation 9

As part of the local delivery plan for delivering the national outcomes for older people, local authorities should give a commitment to quality services, and this commitment should be delivered through the development and support of the workforce.

Recommendation 10

More people need to volunteer to support the activities that create quality of life. Using the Year of Volunteering in 2009 as an opportunity, central government should fund local pilots to test different approaches to volunteering, including further development of time banks, formalising or rewarding volunteering, and focused promotions to younger and older people. Pilots should involve people in as wide a diversity of services as possible.

Chapter 7: Councils and living well

The value of councils

This chapter examines how local authorities are responding to the challenges and opportunities of a changing and ageing society. These are complex and sometimes contradictory: older people are the most active group in civic and community life, but many elderly people feel excluded. Families are fragmented. Elderly people live more independent lives, and more older people will stay in their own homes longer, but that can increase isolation. Many older people are comfortably off, but others are among the poorest. Increasingly people are asset rich but have a low fixed income.

Councils have many roles — as strategic planners and commissioners, as providers and coordinators. They have to be the lead in consulting and engaging their communities, and, crucially, make the political decisions about priorities and use of resources.

Promoting independence and well-being is a potential ally in addressing some of the issues around service rationing. Providing opportunities for people to be engaged with their neighbours and communities is often a far more effective way of countering depression than handing out pills. Submissions show that many councils are committed to this agenda. Andrew Harrop from Age Concern was more critical of local government — *“at local level, there is enthusiasm but it is not translating into joined-up, integrated action on the wider well-being agenda”*.

The evidence we received, particularly from older people themselves and charities, underlined the importance of a wide range of services to the well-being of older people, particularly housing and transport, but also leisure, lifelong learning, environmental services and community safety. ADASS refers to a major engagement and consultation exercise with elderly and disabled people and their carers undertaken by Lincolnshire County Council to identify their priorities for improving their quality of life. Of the eight identified as priorities, reducing social isolation, improving public transport and access to supported housing were in the top four.

This chapter looks at the state of play across all four areas identified by the panel as critical for supporting well-being.

Housing and neighbourhoods

“It is crucial not to see housing and neighbourhoods in isolation from other services. There is, as research has shown over and over, a close relationship between housing and health. Good-quality housing leads to good health. That is absolutely nailed down and proven. Conversely, exactly the opposite is true: poor housing leads to poor health. About every five hours, an older person dies as a result of a fall. This is a serious consequence of poor housing, poor neighbourhoods, defective pavements – which either causes accidents, and in some cases death, or keeps people trapped in their own homes for fear that, if they go out, they will trip over the pavement.”

Professor Alan Walker

The critical importance of good appropriate housing, quality design and inclusive neighbourhoods, was spelt out in many submissions and was discussed at the second oral evidence session, where representatives from CLG and the Housing Corporation attended. There was a much support from across the voluntary sector, health and local government for the government’s *Lifetime Homes Lifetime Neighbourhoods*. The strategy envisages housing and ageing as a cross-government priority, with housing, health and care being increasingly interdependent.

Housing has often been marginalised. The strategy rightly puts housing firmly at the centre — it can be the key to mental and physical health and retaining independence for as long as possible. Many older people live in the worst housing conditions or lack suitable accommodation, with a third of older people

(2.1 million households) living in non-decent or hazardous housing. Poor housing often results in additional costs, such as older people having to go into residential care when they do not yet need to.

Councils have strategic and direct housing roles that impact on the quality and choice of housing for older people. Local authorities have the key role in bringing services together and in planning strategically for the future housing needs of older people in their areas. Councils need to be planning new housing and neighbourhoods for and with an ageing population — future proofing their homes and neighbourhoods.

A key issue raised in many submissions is whether there is going to be enough emphasis on remodelling the existing stock to bring it up to lifetime homes standard. This is going to be complex and expensive, but is critical if Lifetime Homes is going to be a reality for the majority of older people. Many submissions, particularly from older people themselves, were concerned that the government's focus on growth areas and new homes will be at the expense of existing homes and communities.

Numerous submissions spelt out the importance of inexpensive but highly valued services, such as the handy person, that help people stay in their own homes. Supporting People funding was seen as hugely beneficial in helping to keep people independent. Some councils were concerned that ending ring-fencing would see the funds being diverted into other priorities.

Good design was seen as crucial. We have not been designing for an ageing population — small problems, such as lack of toilets, can become significant barriers to older people going out. Poor design can lead to social isolation, with an impact on mental and physical health. Design is not just about pavements or street lighting, but about less obvious factors, such as accessible gardens or building in space so grandchildren can visit or carers be accommodated. Wyre Council told the panel that it is important to make sure adaptations are not clinical or ugly — why should an adapted bathroom not be fashionable?

Professor Walker reminded us of the importance of neighbourhoods as well as housing. Research shows very clearly that older people are committed to their neighbourhoods, even when they are deprived inner-city neighbourhoods; because they have long term investments in them. What is required is a flexible, responsive approach to local services that is in tune with the dynamic nature of older people's lives. *“What may be environmental harmony or good housing fit can change overnight into a crisis, due to a fall, a stroke, bereavement, whatever it is; and the older person then needs a rapid response to keep them in touch with their local community, in touch with their families, and to keep them participating in local life.”*

Chris Holmes from the Housing Corporation pointed out the links between housing options and the personalisation agenda. He used an example from Southwark Council, where there is a small but beautiful programme that helps people to move into smaller accommodation by assessing what people want and then offering a range of help including cash incentives, help with removal costs and personal advice.

Although the personalisation agenda will mean a move away from residential housing, submissions reminded us that there will always be a need for specialist homes. Councils need to plan for a wider range of options, reflecting how people's needs change over time. Councils, the government, housing organisations and developers should also be looking at more imaginative options — cooperative housing, for example, is used more abroad, and can combat loneliness as well as making good housing affordable. Age Concern mentioned home sharing — where a small but growing number of older people are choosing to share their home with a tenant in exchange for companionship and low level informal care. Schemes promoting home sharing are rare and there could be scope for local government to promote them better.

Advice and guidance

The importance of advice and information to underpin the personalisation agenda is equally important when considering housing choices. To enable people to remain independent for as long as possible requires more and better information about the range of housing choices available to older people.

Sheila's story

Sheila heard about the IKAN Team through a friend of hers who had received a home visit and assessment by the Team. Sheila was reluctant to 'bother' the IKAN Team at first but through her friend's encouragement she did contact them, initially because her garden was very overgrown and she needed a gardener. Sadly, Sheila had lost her husband the previous year, they had enjoyed doing their garden together but Sheila, who is now 81, and was struggling to maintain it by herself.



The IKAN Team visited Sheila in her own home and provided information about various approved gardening schemes that could be employed to maintain her garden. The IKAN Team use an informal approach and offer information and advice while using observational skills and their experience to identify other issues they may be able to assist with. During the assessment Sheila discussed with the Team Member how she had been struggling to cope since the loss of her husband and also other concerns about her health, home environment and financial matters.

As a result of this assessment, arrangements were made for Sheila to have a health check with her GP, this actually resulted in her receiving support from a specialist nurse to manage a recently developed but likely long-term health problem.

Sheila was referred for a home fire safety check which resulted in a new smoke alarm being fitted, free loft insulation was fitted to her property and she had a pension check, which highlighted that Sheila was entitled to pension credit and she received eight months back pay.

Knowsley Council's IKAN initiative aims to improve the general health and well-being of people aged over 55 by providing a wide range of services specific to their needs. IKAN stands for "I know a man who can" and helps people with odd jobs, provides advice on benefits, health and social care services and provides links to other agencies who can offer other help.

Councils and the government need to be more active in working with financial institutions to develop equity release models and more competitive long term care insurance products that can unlock some of the £500 billion in unmortgaged equity held by over 65s. At present, there is very low take up of these schemes.

The choices people may need to make can be very complex, with sources of vital information difficult to find. With limited access to information setting out their possible options, older people can feel that they have lost control over their future choices. They may find themselves in residential care before they are ready for it; or staying at home, at risk, when housing with care may be the better option. It is not uncommon for a decision to move to specialist housing to be made after an older person has been hospitalised, and without the proper involvement of the older person themselves in the decision. Age Concern and other third sector organisations pointed out that it is often these kinds of services that are cut, or grants for others to provide them are stopped due to budget pressures.

Connecting to communities

Older people need to engage with services at a fundamental level — shaping services so that, for example, the choices people make are real choices, giving people the tools to shape outcomes based on their experiences. Being involved in delivery means older people's needs are built into planning processes and worked through with them — designing in participation from the beginning.

ESSEX

Essex has a fully developed, award-winning, system of public engagement. Service user engagement is intrinsic to what we do, influencing staff development and training, recruitment and selection, strategy, policy development and service delivery. Service users have an equal standing on the directorate's senior management team, which formulates strategies and directs the activity of the service.

The Older People Planning Group, now with 70 members, is one of six user groups that influence policy and practice within the directorate, and has been involved in the design, monitoring and evaluation of our *Equal Lives Strategy* — within the directorate, and has helped to shape our cross-departmental *Later Life Strategy* — addressing inequality through equality impact assessments, challenging negative stereotypes of older people, and ensuring that all strategies and actions of ECC departments and partners respond to the needs and aspirations of the diverse population of older people in Essex in a joined up manner.

This is particularly important where people feel they have had little say in the past, such as in social care and health. There are clear links here with the philosophy of personalisation, with services being focused around the individual, to maximise control and choice. Personalisation, however, also has to be about service users collectively having a greater say over the planning, the nature and the delivery of services, and engaging with policy making. Councils have a crucial role here, particularly in relation to engagement with health, where despite moves to involve people, there is no democratic basis for it and people still feel distant from decisions. Fledgling Local Involvement Networks will require greater support, but are no substitute for democratic accountability through overview and scrutiny committees and executive involvement in decision making by local government.

The inquiry received numerous examples of engagement — particularly around the POPPs initiatives. How older people's representatives describe their experiences is also looked at in the chapter Lessons from Living. The picture is, however, not entirely positive. At the consultation seminar held in May, some people who sat on older people's forums said they were consulted, but mainly just by being sent documents of proposals, rather than being involved in their development. At the same event, though, the importance of *Better Government for Older People* in promoting genuine engagement was stressed. A key issue was funding — without adequate funding consultation was really just a gesture and not meaningful.

KNOWSLEY

Knowsley have an active user led organisation, Knowsley Older People's Voice with over 400 members, which has won a Guardian Award for Community Leadership. Their activities include investigating and commenting on core aspects of the support for older people. Examples include investigation into public access and transport in one area of the Borough, and production of a DVD, showing the barriers that exist to moving around outside the home; involvement in consultation activities, most recently in an "expert panel" approach, to engage a wider range of public services in their response to older people; and supporting cross-generational work, so that older people can share their skills and experiences, and that suspicions and tensions between older and younger people can be broken down.

Wakefield Council is mapping intergenerational services around the district and early information is showing older people being involved in a number of projects and initiatives, including them running youth clubs, sharing skills with younger people and running exercise classes. Manchester City Council told us about making intergenerational activities more exciting. *"We have turned our community centres*

into much more fun and vibrant places... getting young people to come in, and older people doing things with younger people, like gardening – the younger people do the labour and the older people give advice on what to do. Exercise to music, that kind of thing makes those places a place that people do want to go to. So it is very exciting.”

HAMPSHIRE

An example of intergenerational work, which leads to greater community cohesion is the recent meeting of the Havant Over 50s Forum, which had a special guest speaker, Commander Eddie Grenfell, to talk about his experience of being part of the Arctic Convoys of the Second World War, and his fight to get recognition for the participants. Young people from local colleges were invited to attend. There were approximately 75 older people and 25 younger people there.

DERBYSHIRE

Derbyshire has a new Intergenerational Strategy that sets out development work between younger and older people. It includes older people working with younger people to deliver a range of projects including cookery, IT, gardening, dance, and use of wild food where younger generations can benefit from older people’s experience and wisdom and vice versa. This breaks down age related stereotypes and can help build more cohesive communities. Derbyshire has taken a strategic approach to developing inter-generational practice and has now gained national approved provider standard for intergenerational work.

Innovations in care

Telecare and the use of other assistive technologies could transform the way people live independently at home, by supplementing and in some cases replacing domiciliary care. The use of telecare in West Lothian reduced the average length of stay in a residential care home from 38 months to 12 months. In this study it represented a saving of £47,380 from 2002 – 2006⁶.

“A body of people in Bath University... did some marvellous work, building what they called a Smart House. People with early Alzheimer’s were perfectly well able to look after themselves in a house that was wired in a particular way; thus, if they got out of the bed in the night because they wanted to go to the loo, the bedroom light automatically came on; as they looked for the door and went towards it, the door opened; when they got outside, the light came on in the hall leading only towards the loo... and the whole thing happened in reverse on the way back, with lights going out.”

Clare Rayner, President, Patients Association

With Respect to Old Age (1999) concluded that it was possible to break the cycle of unplanned admissions of older people to hospital and, subsequently, to long-term residential care through prevention and rehabilitation⁷.

When older people leave hospital, there should be a greater emphasis on reablement. By the end of 2006, 60 local authorities had reablement services.

Clare Rayner, President, Patients’ Association stated that *“hospital(s) would much rather have acute, in and out patients to meet their targets. They try to get rid of older people, who need more care and more help. A stroke patient, if he gets proper rehabilitation, may well be able to go home if the home is right.”*

Wandsworth council, after a successful pilot, is to establish a permanent Intake and Reablement Service, which offers all new home care referrals up to six weeks of care, while their need for ongoing care is assessed.

The role of district councils

If we are serious about older people's services being holistic, we cannot see them as solely the responsibility of upper tier councils. We received submissions from district councils which highlighted the contribution they can make to supporting the well-being of older people.

Norwich City Council, for example, told us about working with the NHS on telehealth projects to monitor patient thresholds suffering from chronic diseases, with the monitoring of these projects through the council's community alarm service. Some districts, however, felt that their role was undervalued by county councils and health organisations. Other districts, such as Runnymede, pointed out that although their services were crucial to older people's lives, they were largely discretionary, and were not adequately funded through government grant.

WYRE DISTRICT COUNCIL

If district councils were considered at all, it was because they administer Disabled Facilities Grants and, perhaps, run a Home Improvement Agency/Care and Repair service. But, in a two tier area, district councils can do so much more if only other key agencies understood what districts do and therefore what contribution they can make. Falls prevention illustrates the point. I represent this Council on the Fylde and Wyre Older People's Partnership Board and the first meeting I attended had on the agenda "Falls Strategy". This resulted in a very technical discussion between adult social care practitioners and Primary Care Trust representatives which, as a non-social care or health professional, was somewhat akin to listening to people conversing in a foreign language. The collective view of the district contribution was to provide disabled facilities grants which might prevent older people falling in their homes.

(But) in addition to facilities grants, we could work with our PCT partners to put specific active health sessions on in our leisure centres to help older people retain flexibility and muscle tone. We have a number of staff who go into older people's homes (for example housing and council tax benefit staff) and could brief them to look out for falls hazards and help to link older people to appropriate sources of advice and support both within and outside the Council. However, had no-one been there to identify what district councils can do, the falls strategy would have been developed only on a health and adult social care basis.

Housing is a critical issue for older people, particularly since it is identified as being far less integrated as a service than social care or health, though the impact of bad housing is obvious, not just for well-being but for health as well. Housing is also very much an area where local authorities have key responsibilities. There should be no obstacles to better integration of housing services for older people: local authorities must simply make it happen.

The primary obstacle to helping older people make better housing choices is information. The opportunities are there: for builders, for planners, for furniture designers, and for older people themselves. But these opportunities are not being taken up, and older people are suffering as a result.

Recommendation 11

It should be easier for older people to move home to free up equity, be closer to grown children or live somewhere that is more accessible. It should also be easier for people to stay in their own homes by adapting them. Planners should see lifelong accessibility as essential to all new building. Local authorities should include help with housing choices as a key element of help available locally, but they should be supported with a national gateway from central government that can help identify housing in other areas and provide tools for testing new developments, finding suppliers, and ideas for better design from the best that is available nationally and internationally.

Chapter 8: Never too late to change

Principles for a future system

Across the spectrum of contributors to this inquiry, there was a broad consensus on the principles for a future system.

Sustainability

A reformed system must be sustainable — a settlement that will meet the needs of today, but also be fit for purpose to last for a generation at least.

Transparency

Funding must be transparent. This applies to greater transparency for the money that is going into public services in an area for older people, and the money that is available for the support of any individual.

Fairness

The system must be fair and be perceived to be fair. It is likely that people will accept a system that differentiates between individuals, but the way that this is done must be on basis that is recognised as fair.

Flexibility

The system must be designed with the expectation that users and carers influence the development, design and evaluation of services. This is essential if services are to be responsive.

Accessibility

The system must support users and carers to understand and navigate the system, and to make reasonable choices that reflect their individual needs and preferences, providing dignity as well as quality of life.

A vision for the future – that we should deliver today

It is 2018. Carol Masters is 75 and lives alone in the family home where her and her husband Richard, who has now passed away, raised their two children. Carol retired five years ago at the age of 70 – she could have retired earlier, but chose to stay on as an HR advisor in the bank where she had worked since turning 60.



When she retired, her and her husband used the internet to become more involved in their local community. Her council's website opened doors to many activities they had never considered before. Richard started volunteering: reading stories in the local primary school and helping in local clean-up days. Carol took up yoga again, which she used to enjoy when she was younger. While they were looking for information about things to do, they came across a lot of other information they hadn't expected to find. As a result, when they refurbished their bathroom, they used a company in Salford to provide new sanitary ware which was very stylish but was also certified as being fully accessible.

When Richard died suddenly, Carol's daughter used the notification line from the same website. As well as contacting all kinds of agencies they wouldn't have thought of, from the DVLA to his optician, they suggested a local charity who could help people cope with bereavement and make the right decisions in a difficult time. Carol paid for an hour session with a counsellor who talked to her about losing her husband, and walked her through some of her options for the years to come. Carol considered moving home to somewhere smaller, but felt she wasn't ready.

Now Carol keeps busy with her classes and has started visiting a local church. On her way home one day, Carol notices a dark patch in the middle of her vision. When she asks her GP, he tells her she has a degenerative condition, and will eventually lose her sight. The GP books her in with an assessor to visit her at home.

When the assessor visits, they look together at Carol's life and discuss how her disability may affect her in future. Carol knows what her financial contribution will be, because she and her husband discussed their care finances when they started to consider retirement, and got advice at the time. With her assessor she decides it is time to move home to be nearer to her daughter. They discuss individual budgets and whether Carol would like to control her own care or agree a package for the local authority to manage.

Carol decides to use the voluntary hours her husband saved at the time bank to have someone come and do her garden. The assessor and Carol discuss her mobility and work out routes for her to use public transport to reach all her favourite activities, and the assessor arranges for Carol to get maps of all the public toilets and benches in her area so she can go out confidently. Carol decides to get handrails throughout the house, and the assessor gives her contact details for shops and websites that sell handy tools to help people with visual impairments around the house.

Carol knows she is losing her sight, but she knows she will be able to cope and keep living her life the way she wants to. One day she may need more care, and when she does she will know where to go and that she will get help, like she has always got help before.

Appendix 1: Participants in oral evidence sessions

Evidence Session 1: 22 April 2008

Isle of Wight	Sarah Mitchell	Director, Community services
Isle of Wight	Councillor Dawn Cousins	Cabinet Lead, Adult Social Care
West Sussex County Council	Councillor Patricia Arculus	Cabinet Member for Adults Services
Nottingham City Council	Sallyanne Johnson	Corporate Director, Housing and Health
Crawley Council	Malcom Bray	Development Manager for Health and Well-Being
Crawley Council	Councillor Alan Quirk	Executive Member for Community Engagement
University of Birmingham	Professor Jon Glasby	Director, Health Services Management Centre, School of Public Policy
Patients Association	Clare Rayner OBE	President
Independent Age	Ian Buchan	Director of Care Services
Counsel and Care	Stephen Burke	Chief Executive Officer
Counsel and Care	Caroline Bernard	Policy and Communications Manager
Commission for Social Care Inspection	David Waldon	Director of Strategy
Commission for Social Care Inspection	Carolyn Denne	Strategy Manager

Evidence Session 2: 8 May 2008

Wyre Borough Council	Jan Finch	Deputy Chief Executive
Wyre Borough Council	Councillor Lynne Bowen	Living Healthily Portfolio Holder
Barnsley Metropolitan Borough Council	Martin Farran,	Interim Executive Director of Adult Social Services
Barnsley Metropolitan Borough Council	Councillor David Bostwick	Cabinet Spokesperson for Adult Services
Cumbria County Council	Jill Stannard	Corporate Director Adult Services
Age Concern Cumbria	Mary Bradley	Director
Department for Communities and Local Government	Terrie Alafat	Director of Housing Strategy and Support
Department for Communities and Local Government	Luke O Shea	
Better Government for Older People	Mervyn Eastman	UK Director
Age Concern	Andrew Harrop	Head of Policy
Housing Corporation	Chris Holmes	CBE
In Control	Simon Duffy	Chief Executive
Unison Local Government Service Group	Helga Pile	National Officer
Unison National Social Care Forum	Jackie Lewis	Vice-Chair
Sheffield University	Professor Alan Walker	

Evidence Session 3: 21 May 2008

Oxfordshire County Council Services	Simon Keary	Business Manager, Social and Community
Manchester City Council	Councillor Basil Curley	Executive Member for Adult Social Services
Manchester City Council	Caroline Marsh	Director of Adult Social Care
Buckinghamshire County Council	Rita Lally	Strategic Director, Adult Social Care
Brunel University	Professor Peter Beresford	
Local Government Association	Anne McDonald	Programme Director
Local Government Association	Councillor Gareth Barnard	Vice Chair, Community Well-Being Board
British Medical Association	Professor Vivian Nathanson	Head of Science and Ethics
British Medical Association	Dr Helena Mckeown	Chair of Community Care Section
Oxford Institute of Ageing	Kenneth Howse	Senior Research Fellow
British Society of Gerontology	Dr Kate Davidson	President,
Help the Aged	Kate Jopling	Head of Public Affairs
NHS Confederation	Jo Webber	Deputy Policy Director
ADASS	Dwayne Johnson	Lead on Adult Protection

Appendix 2: Written evidence

001 Aberdeenshire Council

Bill Stokoe, Strategic Development Officer

002 ADASS

John Dixon, President

003 ADSW

Kenny Leinster, Chair of Older People's Sub Group

004 Age Concern

Andrew Harrop, Head of Policy

005 Age Concern, Peterborough

006 Age Concern, Lewisham and Southward

007 Anchor

008 Barnsley Borough Council

009 BASW

Ruth Cartwright, BASW Professional Officer

010 Blackburn and Darwen Borough Council in conjunction with Blackburn with Darwen Older People's Partnership

011 Bournemouth County Council

Ivor Cawthorn, Head of Adult and Community Support

012 Bracknell Forest Borough Council

Councillor Dale Birch, Executive Member for Adult Services

013 British Medical Association (BMA)

Vivienne Nathanson, Director of Professional Activities

014 British Society of Gerontology

015 Buckinghamshire County Council

016 BUPA

017 Carers UK

Katherine Wilson, (acting) Policy and Public Affairs Manager

018 Commission for Social Care Inspection (CSCI)

019 Counsel and Care

020 County Councils Network

John Courouble, Senior Policy Officer

021 Cumbria County Council

Michael Hyatt, Assistant Chief Executive

022 Daventry District Council Daventry and District Over Fifties Forum

023 Derbyshire County Council

Bill Robertson, Strategic Director

024 Devon County Council in Partnership with the My Life My Choice (POPPS)

025 DMP

Dr Mervyn Eastman, UK Director

026 Edinburgh City Council

Glenda Watt, Strategy Manager for Edinburgh's Plan for Older People

027 English Community Care Association

Martin Green, Chief Executive

028 Essex County Council

Craig Elliott, Policy Analyst

029 Gateshead County Council

030 GSCC

Sir Rodney Brooke, Chair

031 Hampshire County Council

Ken Thornber, Leader

032 Haringey Council

Councillor George Meehan, Leader of the Council

033 Hartlepool Senior Forum

034 Help the Aged

Kate Jopling, Head of Public Affairs

035 Hertfordshire County Council

Mark Lobban, Assistant Director

036 Housing Corporation

Gill Street, Public Affairs Officer

037 In Control

038 International Longevity Centre (ILC-UK)

Lisa Wilson, Consultant

039 Independent Age

Gary Loke, Policy and Public Affairs Officer

040 Isle of Wight Council

041 Joint government submission

042 Knowsley Council

Barbara Hitchins, Head of Integrated Locality Services

043 Lancashire County Council

044 Lancaster Older Peoples Partnership Board (OPPB) and Wyre and Fylde OPPB

045 Leicestershire County Council

046 Lincolnshire County Council

Carolyn Kus, Assistant Director

047 Local Government Association (LGA)

Matthew Hibberd, Policy Consultant

048 London Borough of Merton

Angela Chu, Housing Strategy Manager

049 London School of Economics (LSE)

Linda Pickard, Research Fellow

050 Luton Borough Council

Penny Furness-Smith, Corporate Director

051 Manchester City Council

Caroline Marsh, (acting) Director

052 Middlesbrough Social Care Department Middlesbrough Senior Citizens Forum and Service Users

053 Moray Council

054 NHS Confederation

Jo Webber, Deputy Director of Policy

055 Norfolk County Council

Daniel Cox, Leader

056 Northern Trust

057 Norwich City Council

Nigel Andrews, Tenancy Support Manager

058 Nottingham City Council

Sallyanne Johnson, Corporate Director, Housing and Health

059 Older People s Forum

060 Partnership Assurance

Ian Owen, Chairman

061 Pendle Seniors Group

David Rowbotham, Secretary

062 Personal Contribution

Professor Alan Walker

063 Personal Contribution

Ramsay Clifford Jennis

064 Personal Contribution

Partha-Sarathi Trivedi

065 Personal Contribution

Anonymous

066 Personal Contribution

Senior Local Government Officer, Christine Holloway

067 Peterborough Council

Keith Sumner, Interim Director of Adult Social Services

068 The Princess Royal Trust for Carers (PRTC)

Alex Fox, Assistant Director

069 Resolution Foundation

Claudia Wood, Policy and Research Manager

070 Richmondshire District Council

Elizabeth Smith, Executive Director

071 Rochdale Metropolitan Borough Council

Kalsoom Iqbal, Policy and Performance Officer

Appendix 2: Written evidence (continued)

072 Royal Borough Of Kensington and Chelsea

Henry Bewley, Health Policy Officer

073 Royal College of Nursing

Lisa Maith, Paliamentry Officer

074 Runnymede Borough Council

Deborah Blowers, Director of Housing and Community Services

075 Rugby Borough Council

Karen Stone, Director

076 Sefton Partnership for Older Citizens (SPOC)

077 The Senior Council for Devon

Ken Crawford, Secretary

078 Sheffield City Council

Philip Malyan, POPPS Programme Manager

079 Sheffield s Older People s Partnership Board

080 South East Leaders (SECL) and South East County Adult Social Care Members(SECAS)

Kevin Greenhough, South East Counties, Research and Administration

081 Southend-on-Sea Borough Council

082 Stevenage Borough Council

Laurel Farrington, Strategy Manager

083 Surrey County Council

Councillor Sally Marks

084 Tameside Council

Stephanie Butterworth, Director of Adult Services

085 Tendring District Council

086 Thurrock County Council

Rita Cheatle, Joint Planning Officer

087 Torbay Council

Aaron Standon, Head of Social Work

088 UKHCA

Colin Angel, Head of Policy and Communication

089 UNISON

090 Unite (T&G) Section

Penny Morley and Peter Allenson

091 Voluntary Action Sheffield

Jasmine Warwick, Planning and Partnership Officer

092 Wakefield Council

Michelle Bradley, Service Manager

093 Warrington Borough Council

094 West Sussex County Council

John de Mierre, Cabinet Member for Adult s Services

095 Wyre Borough Council

Jan Finch, Deputy Chief Executive

Appendix 3: Literature review

Government publications

Department for Communities and Local Government, *Lifetime Homes, Lifetime Neighbourhoods*, February 2008

Department of Health, *White Paper: Our Health, Our Care, Our Say*, January 2006

Department of Health, *Putting People First: a shared vision and commitment to the transformation of adult social care*, December, 2007

Department of Health, *Carers at the Heart of 21st Century Families and Communities*, June 2008

Department for Work and Pensions, *Opportunity Age: meeting the challenges of ageing in the 21st century*, March 2005

Other sources

Caring Choices Coalition, *The Future for Care Funding*, January 2008

Commission for Social Care Inspection, *The State of Social Care in England 2006–07*, CSCI, 2008

Commission for Social Care Inspection, *Transforming Social Care*, January 2008

Commission for Social Care Inspection, *A consultation on the framework for the registration of the health and adult social care providers*, June 2008

Counsel and Care, *Care Contradictions: higher charges and fewer services*, July 2007

Joseph Rowntree Foundation, Hirsch, Donald, *Facing the cost of long-term care: towards a sustainable funding system*, 2005

ILC-UK, *A National Care Fund for Long-term Care*, February 2008

Joseph Rowntree Foundation (2006), *Paying for Long Term Care: Moving forward*, 2006

Mike Murphy presentation, based on Office for National Statistics 2006-based projections (<http://www.gad.gov.uk/>). Government Actuary Department (GAD)

Kings Fund, Wanless, Derek, *Securing good care for older people: taking a long-term view*, 2006

References

- 1 Office of the Deputy Prime Minister (2006). *Making Life Better for Older People: An economic case for preventative services and activities* Wetherby: ODPM
- 2 *In the Know*, Carers UK, 2006
- 3 Facts about Carers, Carers UK, July 2005
- 4 *Informal Care for Older People provided by their adult children: projections of supply and demand to 2041 in England*, Report to the Strategy Unit (cabinet Office) and the Department of Health. *PSSRU Discussion Paper 2515*, March 2008, www.pssru.ac.uk/pdf/dp2515.pdf.
- 5 Sophie Moullin (2008) *Just Care? A fresh approach to adult services*, Institute for Public Policy Research (IPPR)
- 6 Bowes, A and McColgan, G (2006) *Smart technology and community care for older people: innovation in West Lothian*. Age Concern Scotland, Edinburgh
- 7 The Royal Commission on Long Term Care (1999) *With Respect to Old Age: Long Term Care – Rights and Responsibilities*, a report by the Royal Commission on Long Term Care. London: The Stationery Office

Panel of members biographies

Clive Betts MP (Chairman)

Labour MP for Sheffield Attercliffe since 1992, Clive has chaired the All Party Parliamentary Local Government Group for the past year. He currently sits on the Communities and Local Government Select Committee, and was a member of its predecessor, the Transport, Local Government and the Regions Committee, since 2001. Prior to entering Parliament, Clive was leader of Sheffield City Council.

Lord Best OBE

President of the Local Government Association, Richard Best has sat on the crossbenches in the House of Lords since 2001 when he was made a life peer. He has been a Director of the British Churches Housing Trust and the National Federation of Housing Associations, and led the Joseph Rowntree Foundation and Housing Trust until 2006. He is currently President of CCC, a coalition of commercial, charitable and public service organisations with a mutual interest in providing better care for current and future generations of older people.

Jim Dobbin MP

Labour Member for Heywood and Middleton since 1997, Jim has sat on the Communities and Local Government Select Committee for the last year. He worked as a microbiologist in the NHS in Scotland and Oldham for some 30 years, and was a Rochdale councillor for 12 years, becoming leader of the council shortly before his election to Parliament. He is also a founder member of the All Party Group on Palliative Care, and presented a Ten Minute Rule Bill in the House of Commons on the subject.

Baroness Greengross OBE

Baroness Sally Greengross is a Commissioner for the Equality and Human Rights Commission. She has been a crossbench member of the House of Lords since 2000 and chairs three All Party Parliamentary Groups, on corporate social responsibility, on intergenerational futures, and on continence care. She also holds posts on the All Party Parliamentary Group on dementia and ageing and older people. Sally is Chief Executive of the International Longevity Centre UK, and co-Chairs the Alliance for Health and the Future. She is also Chair of the Advisory Groups for the English Longitudinal Study on Ageing (ELSA) and the New Dynamics of Ageing (NDA). She was Director General of Age Concern England from 1987 until 2000, and is now their Vice President. Until 2000, she was joint Chair of the Age Concern Institute of Gerontology at Kings College London, and Secretary General of EuroLink Age.

Lord Hanningfield DL

Leader of Essex County Council since 2001, Lord Hanningfield was made a Conservative peer in 1998. He is currently an opposition spokesperson for transport in the House of Lords, having previously been responsible for communities and local government, and education and skills. In 2001, he co-founded the Localis think tank, intended as a forum for the development of new ideas for local government.

Philip Hollobone MP

Philip Hollobone has been the Conservative MP for Kettering since 2005, and continues to serve as a Kettering Borough Councillor. In previous years, he also represented the Borough of Kettering on the local Community Health Council, Northamptonshire's Health Scrutiny Partnership and Northamptonshire's Campaign to Protect Rural England. In parliament, he sits on the Transport Select Committee.

Joan Humble MP

Labour MP for Blackpool North and Fleetwood since 1997, Joan is currently a member of the Work and Pensions Select Committee. Prior to entering Parliament, she was a full-time Lancashire County councillor for twelve years and chaired the social services committee. Alongside her membership of the Local Government APPG, she chairs the All Party Groups on personal social services, childcare, and social care.

Barbara Keeley MP

Labour Member for Worsley since 2005, Barbara is currently Parliamentary Private Secretary to Harriet Harman as Minister for Women. Before becoming an MP, she worked for more than a decade as a consultant and adviser on community regeneration, and then as a consultant and adviser for the Princess Royal Trust for Carers, and other regional and national charities and as a researcher into issues in primary health care. She was the Parliamentary Champion for Carers in 2007, during which time she introduced a Private Members' Bill on carers and initiated a Westminster Hall debate on the issue. She was also appointed by Gordon Brown last year to chair the Labour Party's manifesto group on Social Care.

Greg Mulholland MP

Liberal Democrat Shadow Health Minister Greg Mulholland is the Older Person's Spokesperson for the Liberal Democrats on the party's health team. Previously he was Liberal Democrat Shadow Schools Minister and before that was an International Development spokesperson. Greg was elected to Parliament in 2005, having sat on Leeds City Council for two years previously, including being Lead Member for Corporate Services. He is a member of the Work and Pensions Select Committee.

Dr Doug Naysmith MP

Labour Member for Bristol North West since 1997, Doug is a member of the Health Select Committee. He is also currently chair of the Parliamentary Labour Party's Departmental Committee for Health and Social Services. Prior to entering Parliament, he was a Bristol City councillor for 17 years, and worked at the Bristol University Medical School.

This report was launched at a Parliamentary reception on 22 July 2008 by the Rt. Hon. Hazel Blears MP. The reception was sponsored by Northgate Information Solutions.



Northgate Information Solutions is a leading provider of innovative services to the public sector and utilities markets. It is committed to high quality public services and understands the public sector. That knowledge is core to its business.

Northgate's task is to enhance public value through the intelligent use of people and technology, and to share in the economic and social benefits that this brings. Northgate Public Services is pleased to support this valuable contribution to a critical debate. As this report so cogently sets out, local government is facing a tremendous challenge to deliver a transformed service for the older generation of today and of tomorrow.

As a provider of innovative services to the public sector, we are acutely aware of the complexities involved in delivering a service that genuinely responds to the needs of the individual, while enabling the efficiencies that are essential if we are to meet ever increasing demand. In our work with local government and social housing, we increasingly recognise the central importance of streamlined decision-making: this report makes a powerful case for key steps which would rationalise how we deliver for older people. If we are going to galvanise all the resources to meet the challenges ahead, this is surely the kind of approach that we must consider for the future.



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