REPORT TO:	Executive Board
DATE:	1st December 2011
REPORTING OFFICER:	Strategic Director - Communities
SUBJECT:	'Caring for our Future: Shared ambitions for care and support' Consultation
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide the Board with an overview of the Government's *Caring for our Future: Shared ambitions for care and support* consultation document and proposed response.

2.0 **RECOMMENDATION: That the Board:**

i) Note contents of the report; and

ii) Agree the consultation response on behalf of the Borough Council (Appendix 1)

3.0 **SUPPORTING INFORMATION**

3.1 On 15 September 2011, the Government launched *Caring for our Future: Shared ambitions for care and support* – an engagement with people who use care and support services, carers, local councils, care providers, and the voluntary sector about the priorities for improving care and support.

3.2 *Caring for our Future* is an opportunity to bring together the recommendations from :-

- The Law Commission (published in May 2011) : The Commission report said that adult social care law is outdated and confusing, making it difficult for people who need care and support, their carers and local authorities to know what they are entitled to. It recommended bringing together all the different elements of social care law into a single, modern, adult social care statute.

- The Commission on the Funding of Care and Support (published in July 2011): The Commission recommended that the amount that people have to spend on care over their lifetimes should be capped, although people in care homes should continue to pay a contribution towards their living costs. The Commission also recommended that the current system of means-tested support should be extended, so that

more people can get additional help in paying for care.

- The Government's Vision for Adult Social Care (published in November 2010)

3.3 The recommendations from these Commissions etc will be used as a basis for exploring what the priorities for reform should be and the Board are invited to comment on the consultation to inform these future discussions.

3.4 The Government have identified six areas where they believe there is the biggest potential to make improvements to the care and support system, as follows:-

3.4.1 Improving quality and developing the workforce
How can the quality of care be improved and how can the workforce be developed in order to do this?

3.4.2 Increased personalisation and choice
How can people be given more choice and control over the care and support they use and help make informed decisions?

3.4.3 Ensuring services are better integrated around people's needs
How can better connections be built locally between the NHS and other care services?

3.4.4 Supporting greater prevention and early intervention
How can more effective prevention and early intervention support be given to keep people independent and in good health?

3.4.5 Creating a more diverse and responsive care market
How can we ensure that there is a wide range of organisations that provide innovative and responsive care services?

3.4.6 The role of the financial services sector in supporting users, carers and their families
What role can the financial services sector play in supporting care users, carers and their families?

3.5 As part of *Caring for our Future*, the Government also want to hear people's views on the recommendations made by the Commission on Funding of Care and Support and how these proposals should be assessed, including in relation to other potential priorities for improvement. The Commission's recommendations present a range of options, including on the level of a cap and the contribution that people make to living costs in residential care, which could help to manage the system and its costs.

3.6 As this is such an important issue for the Local Authority and its partners, in relation to the future provision of Adult Social Care, Halton wish to submit a local response to the consultation exercise

and as such staff from Halton Borough Council, Key Health Stakeholders (5 Borough Partnership, Hospitals, PCT and Public Health), Domiciliary Care and Residential Care providers and Registered Housing Providers were invited to comment on the consultation questions.

Opportunities have also been taken to raise the consultation with partners during events/meetings that were already scheduled e.g. Health Partnership Board held on 13th October, Health Policy and Performance Board 8th November and the Developing Older People's Services Event on 23rd November 2011.

A list of the consultation questions, along with proposed responses can be found in **Appendix 1**

3.6 The engagement exercise will run until early December, but the Government are asking for written comments as early as possible in order to inform discussions. **The deadline for written comments is 2nd December 2011**

3.7 The discussion will inform a Government White Paper on Social Care reform and a progress report on Funding Reform that will be published in **Spring 2012**.

3.8 Further details regarding the engagement exercise can be found on the DoH Website at the following link:

http://caringforourfuture.dh.gov.uk/

The Commission on Funding of Care and Support report can be found at :

http://www.dilnotcommission.dh.gov.uk/our-report/

4.0 POLICY IMPLICATIONS

4.1 Whilst the detail of the implications for the Local Authority will not be known until the White Paper is published, it can be assumed that there will be a number of potentially significant implications for the Council.

4.2 In particular, HealthWatch may have a role in supporting people to have more choice and control over the care and support they use by providing help to make informed decisions, ensuring services are better integrated around people's needs and improving quality through HealthWatch's role in gathering information and submitting recommendation reports.

4.3 The Health and Wellbeing Board and Clinical Commissioning Groups will have a role to play in supporting any changes that are identified in the forthcoming White Paper, with the Joint Strategic Needs Assessment identifying where prevention measures could be

put in place.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Until the White Paper is published it is not possible to identify specific financial implications, however making changes to the funding system for care and support, as discussed in the Commission on Funding of Care and Support's report, would impact on all aspects of the care and support system.

5.2 The financial implications of the White Paper will need to be considered along side competing priorities in the current financial climate. These implications may be come clearer with the progress report on Funding Reform due in Spring 2012.

5.3 One of the recommendations contained within the Law Commission report published in May 2011, was a recommendation concerned with *'building a single, streamlined assessment and eligibility framework',* which would lead to the potential of significant financial and resource implications for not only Halton but nationally.

5.4 Other potential implications may include:

- Greater role for commissioners in developing the care and support market in order to meet diverse and increasing needs.
- De-commissioning of existing services.
- Relationship building/management locally between the NHS and other care services – in a time where there is a lot of organisational change in all sectors.
- Establishing relationships with financial services in supporting care users, carers and their families – demystifying the financial support sector.
- Impact on social care staff in terms of their training, development and registration requirements
- Impact on the Complaints process and quality of information
- Greater emphasis on the work associated with early intervention and prevention (i.e. Team around the Family approach)
- Impact on the role of the Local HealthWatch, Health and Wellbeing Board and Clinical Commissioning Group in terms of supporting any changes that are identified in the forthcoming White Paper, as a result of this consultation.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The consultation is only concerned with Adult Social Care

6.2 Employment, Learning & Skills in Halton

There may be employment opportunities developed as a result of developing the care and support services market to meet increased

and diverse needs. This may also impact on workforce development.

6.3 **A Healthy Halton**

Any changes as a result of the consultation will impact directly on the health and wellbeing of Halton residents in how they access care and support services and what services are to be made available.

6.4 **A Safer Halton**

The consultation does not impact on community safety

6.5 **Environment and Regeneration in Halton**

Depending on the outcome of the consultation the impact on urban renewal is not yet known. Physical outlets for delivery of care and support services may need to be adapted, increased etc

7.0 RISK ANALYSIS

7.1 Until the White Paper is published it is not possible to identify specific risks at this time. However, with any significant changes to care and support appropriate risk and impact assessments will need to be undertaken as part of any change.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 An Equality Impact Assessment (EIA) is not required for this report

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection	Contact Officer
Caring for our future: shared ambitions for care and support	http://caringforourfuture.dh.gov.uk/	Louise Wilson
The Commission on Funding of Care and Support report	http://www.dilnotcommission.dh.gov.uk/our-report/	Louise Wilson

Appendix 1

Consultation Questions and Draft Response

1. What are the priorities for promoting improved quality and developing the future workforce?

The whole area of workforce is a critical and priority area in order to ensure that the Adult Social Care agenda is achieved. It is essential that the Social Care sector has in place a workforce which is confident, appropriately trained, qualified and empowered. To address these key issues successfully a workforce strategy needs to be implemented at local, regional and national levels which underpins and interlinks with overall local, regional and national Adult Social Care Strategic Objectives – it can't stand alone or be seen as a separate entity.

An effective workforce strategy should address such key areas as:

- Workforce data
- Workforce re-design
- An autonomous workforce
- Providing learning, qualifications and standards
- Having in place a recruitment and retention policy
- Having strong leadership & management.

Issues and barriers that the sector may need to overcome in this area are:

- Smaller state sector and public funding gap in adult social care
- Imbalance between supply & demand
- Social care characteristics of the workforce
- Recruitment & retention
- Sector complexity & uncertainty
- There is a need to engage with the workforce, involving the workforce to identify what is required at a local level.

Integrated training and continuous development through skill acquisition and evaluation is also key. Consideration could be given to accreditation type routes for social care sector staff. A leadership Coaching/Mentoring national programme, national guidance on standards of training, regulation / supervision of practice etc may also be beneficial. There is a strong correlation between an effective, skilled and knowledgeable workforce with that of providing (and maintaining) and improving the level of quality of care.

A standard definition of quality is easy to achieve as a high level statement e.g. promotion of social inclusion, treated with dignity and respect, promoting choice and opportunity. However, this can mean different things to different people so at a micro level it would be extremely important to have a range of quality indicators to ensure that quality is appropriately measured.

If there is an agreed national standard of quality there should be use of evidence to support this to use in developing policies and approaches locally. It needs to be recognised that this is not a one size fits all situation. There

needs to be local accountability, community involvement and engagement in order to implement successful local solutions which are tailored to address the different needs of our diverse community. The key challenge would be to bring all community assets together in order to address the different needs of our diverse community.

The overarching ambitions should be communicated at a National level, however, it is important that local professionals and practitioners have the opportunity to utilise their own local skills and knowledge to deliver the most effective service for their population.

Health and Social Care has traditionally performed to agreed frameworks or best practice guidelines and it could be argued that this methodology has been successful. However, there is a direct correlation between both output and outcome measures and quality frameworks. As the Government removes large numbers of previous targets there has to be an understanding that this could create difficulties in working toward a quality framework as you would not have the required measures in place to prove effectiveness.

Definitions of quality need to be driven by the individual care plan or assessment of need and what the individual wants to achieve and not what the service would want to achieve. The standards would need to be flexible and understandable enough for a person to be able to apply them themselves and would need to give examples of essentials on what was required to meet the standard. Individuals may require support to enable and empower them to set the standards for their own care.

The recent Select Committee Report on CQC Accountability identified concerns raised over the lack of inspections during the 2010-11 period. The balance between registration and compliance activity was found to be unequal and prioritised poorly. How will a standard definition of quality be assessed? The impact of a less well monitored system on quality, reliability and safeguarding needs to be further considered.

In respect to achieving improved outcomes individuals need to be much better informed than they are currently, to allow them initially to make the right decision about the types of care and who provides it, but consequently to enable them to assess the quality of the service they are receiving. Social marketing could be used to inform and change people's expectations of what they will receive from social care and how they can influence this.

This is important when considering the need for quality measures and some form of audit because if the market changes significantly to allow people to commission their own services there is a need to ensure that there are controls in place to support their decisions.

Localities should strengthen their role in ensuring the 'market' has agencies and structures in place to ensure what's available is of a high quality. Citizens and users need to be central to the development of these processes at a local level.

There is value in recognising preventative (non-statutory) services in delivering quality services and the savings they generate for statutory services in national spending plans and initiatives such as community budgeting.

Who is responsible for driving forward continuous quality improvement depends on local integration and partnership working, but if there is an overriding quality framework that is agreed by all partners then responsibility and accountability could be agreed at a local level. Health and Well-being boards and associated sub-structures should have a role to play in quality improvement.

We need to increase the use of a variety of mechanisms to capture user experience of quality through technology, questionnaires, groups, use of reviews, user forums etc and maximise the role of Local Involvement Networks/Local HealthWatch.

There needs to be an easy and transparent method of feedback that also allows for a speedy response. By utilising technology we could easily build systems that allow people to offer their opinions on a service prior to it becoming a full complaint. This would help relationships between professionals and the public, but would also improve the complaints service. A system like Patient opinion could offer that type of service that could feed directly to commissioners or service managers.

2. What are the priorities for promoting increased personalisation and choice?

Halton is committed to the principle that the personalisation agenda is a platform for the future way that services are designed, orientated and delivered. However there has to be a greater acknowledgement that personalisation, personal budgets etc will be a positive for some people, but not all and it does feel like the expectation is that it works for everyone. For example there needs to be urgent dialogue or review of how self directed support is being delivered when supporting older people. The numbers of older people receiving adult social care services far outweigh other age groups, yet the numbers in receipt of direct payments is extremely small - this appears to suggest that something is not working within the current systems. It's not about making the system easier it is about understanding if the system is right for an individual. There has been an accepted thought process that personalisation is the way forward for all, however, there is evidence to say that this isn't the case and that for some people traditionally commissioned services are far more effective in delivering the care and support they require. Traditionally commissioned services can still be the appropriate route for many people, but only if there is enough intelligence and evidence to support the decision to commission.

There are many people who have criticised Councils for their commissioning approaches and style, however there are many examples where Councils have managed to perform well in 'managing the market' and Councils have been able to introduce robust mechanisms to commission services. Personalisation is a rapidly expanding market as councils seek to meet the Government target of increasing personalisation to all eligible adult social care

clients by April 2013. This new dynamic will have significant implications upon how councils undertake commissioning on behalf of local communities. It is believed that self directed support is beginning to fragment this market and Councils are finding it more difficult to manage the market (will the market be able to cope with these fast moving changes?) and it is conceivable that in the future extra resources may be required to monitor the quality, safeguarding, effectiveness and efficiency of self directed services. What will this mean for financial and budgetary control?

In terms of the impact on the dynamics of the market, users need to see a visible change in the level of choice and control they can exercise. However it must be noted that generally what people who receive social care want are high quality responsive services that treat them as adults with skills and abilities and promote their independence, dignity and respect. Focusing on these areas with the social care workforce will improve the quality of service provision rather than thinking there is a wide market out there so users can pick and choose and change if it doesn't meet their needs and therefore this drives up quality.

The use of direct payments for residential care is welcomed to improve choice and control, however, locally it is the most frail elderly people who enter residential and nursing care and it is debateable whether this path would be appropriate. The focus needs to remain on improving personalisation within the home and ensuring that people remain in control of their environment and the support that they receive. The potential could be that the choice people would have may be used to drive up standards locally as a more competitive market is opened up.

If the residential care is viewed as their normal place of residence, it should be treated as the person in their own home, with a similar range of choices and opportunities, including any payments, which should improve quality of life and outcome for people. This range of choice and options may not be sustainable for some residential care home providers or social care providers. It is difficult to assess the risks of this, there is some evidence that this has been successful in other areas for example an extra care scheme in Chorley, but there is no evidence of how this would work in a more deprived area like Halton. There might be some concerns over how an individual with complex health needs would be able to manage the process of direct payments etc.

Commissioners will need to think more creatively about how information is provided, each provider offers some form of specialist information, but this needs to be considered alongside with the risk of duplicating the more generic provision. Low-level support services need to co-ordinate their pathways to understand when their service stops and a partners service begins.

For the majority of users, support or information to become informed users is achieved through personal relationship development with the people supporting them to make choices – this can be family, friends and / or assessment / brokerage staff. The Halton Bridge Builders / Sure Start to Later Life model is based on this.

With the implementation of Local HealthWatch, in 2012, individuals will have access to support to make informed choices about health and social care services. However, there is a need to continue to develop the range of avenues through which people can access a support including advocacy, brokerage, support and information on their locality and services.

There needs to be consideration to support sector based quality assurance systems. The value of local self-help/peer-support and advocacy groups, advice agencies needs to be recognised. For vulnerable & disadvantaged people - recognise need for funding for user led organisations, peer-support and advocacy groups and for advice agencies.

People, especially older people, use their direct payments to purchase care services either from the regulated sector or the non-regulated sector of personal assistants, family, friends and neighbours, or self-employed individual care assistants. Whilst it is accepted there can be benefits in services being non-regulated it also creates a fragmented system where the powers to protect are weakened. Unfortunately there are already many examples of older people been exploited by the people who are providing that care, including many examples where older people have been referred to Safeguarding teams within Local Councils. In addition the 'employment' of people to support the needs of older people has lead to some older people being challenged through the judicial systems. Whilst it can be accepted that Councils could be doing more to advise older people, the two tier employment and non regulation system has lead to increasing numbers of older people at risk and we believe it will continue to do so.

Further work needs to be done on Performance Systems. There is a belief that direct payments are inconsistently applied across organisations and that many Councils are adopting different performance systems to count people accessing direct payments, for examples some Councils are not counting older people who are 'virtual' direct payment recipients whilst others do count them. This inconsistent approach is making it difficult to benchmark and measure accurately the performance nationally.

Major change and information programmes are required to inform the workforce about the benefits and opportunities of personalisation. This should be supported by a change in culture, behaviour and attitude by recruiting, appraising and training for the particular attitudes and behaviours required.

There is a need to embed workforce redesign and workforce innovation in practice and organisational culture. More focus is required on encouraging innovative and creative ways of working i.e. with assistive technology and developing joint working with other sectors to support integrated solutions to service delivery and workforce development.

3. How can we take advantage of the Health and Social Care modernisation programme to ensure services are better integrated around people's needs?

Due to the current proposed changes within Health and the significant resource implications facing social care it is extremely difficult for

organisations to operate in an integrated way. Loss of personnel and too much focus on managing challenging budgets will inevitably lead to organisations looking inward rather than outward. This will only change when social care funding levels are appropriate to the needs of the population.

Any care pathway that crosses between health and social care should be integrated. Usually this is around long-term, chronic or complex conditions, but should apply to children's, older people, learning difficulties, long term conditions, challenging families and mental health, especially dementia. The focus should be on pathways of care rather than organisational integration. Whilst this is complex – development around pathways of complex care is progressing. However, there will be a need to address the issue of information systems and data sharing. Clear objectives should be stated by all involved to reduce any concerns.

Different funding streams and eligibility criteria means that integration can break down when one service changes the funding or eligibility. If teams *are* integrated then the funding needs to be integrated or merged too.

Strong strategic leadership in the locality from the respective organisations is required. The Health and Wellbeing Board and sub structure will have a role in integrating Health and Social Care with clearly defined projects and authority to make decisions and implement them.

Integrated services with agreed, shared objectives, shared information and a joint delivery of care should include care being designed and delivered around the person and family and/or carers. Learning should be taken from existing integrated pathways of support, such as 'team around the family' in Children's services and other local community Multi Disciplinary Teams which encompasses support to the structures and networks in peoples lives and promoting their development – this therefore includes meeting 'high' level needs as well as education, development, skills, cohesion and support around accessing the locality, problem solving etc.

A local example of a person-centred service that met the needs of the individual in a timely and integrated way is the Halton Intermediate Care service. This offers an integrated service aimed at reducing hospital, residential and nursing admissions, as well as improving the access to rehabilitative services.

There needs to be dissemination of good practice and evidence that person centred, integrated services will improve the 'customer journey'.

Integrated services can reduce duplication and multiple assessments. We need to develop champions within services to lead the integration and identify barriers locally. Ensure collaborative working and co production of materials with people who access services to ensure effective handover of a person's care from one part of the system to another. Transition is a key part of integrated services, there are potential risks with service users being 'lost' to services during this process and the need to ensure that all stakeholders are offering joined up services is vital.

This can link back to information provision as often the difficulty for the public as well as professionals is how they 'navigate' the health and social care system. In some areas the need for specialist support has been identified, for example Dementia Care Advisors, to bridge the gap from clinical diagnosis and community or social care support.

There is enough academic and practical evidence to support the case for integrated services, however, there is a need for clarity on expected outcomes and associated criteria. This can be extremely problematic in some low-level services or information providers as service users often stick to one service they trust. Clear performance indicators are required to ensure compliance. Pilot sites for particular areas of work could be developed and an offer of support from Government.

There are lots of examples of innovation in services. In respect to care elements there needs to be recognition that vulnerable older people are still able to play an important part of the community. This can take the shape of community based services offering in-reach services to residential care residents or hospital working with voluntary sector organisations and faith groups to give added benefit to hospital discharge.

An example of this was a discharge meeting with a stroke patient and family which consisted of one social worker and four clinical staff. All of the health needs and the basic social care needs (minor adaptations) were dealt with, but there was no-one who could consider that the patient wanted to go and get his morning paper, wanted help on a computer to continue his work on the family tree and go for a pint on a Friday. These areas could be supported by the voluntary or community sector yet they are very rarely included in the pathway or any discharge process. This is an innovation that could significantly improve integrated care.

4. What are the priorities for supporting greater prevention and early intervention?

There has been a significant and growing emphasis on the need to change the way adult social care services are delivered in response to the demographic challenge of an ageing population, and we need to ensure that the whole system response which will be built around personalised services with increased emphasis on prevention and early intervention is able to effectively support this.

There are a number of National documents that further support the development of the prevention and early intervention agenda. The **Government White Paper: Our Health, Our Care, Our Say (January 2006)** outlines the overall shift from complex care to prevention and this is further evidenced in **Putting People First – Transforming Adult Social Care (2007)** and **High quality care for all (Darzi report 2008)**. These documents demonstrate the importance of prevention and how an agreed model of early intervention could work across a number of service areas.

However there needs to be an overall understanding of the definition of prevention and that in order to be effective it needs to be universally accepted by all.

This is an issue that needs to be tackled by Government. The health service as seen by the majority of the public is only covering the point of delivery, usually due to a crisis. To achieve a cultural change there would need to be a radical shift of resources from acute care into community based prevention. This would be extremely unpopular with the voting public, so there needs to be a period of education to help people understand that Health, Social Care, third sector etc are all part of the same process and therefore a shift in resources fits with supporting the NHS. Development of high level indicators at the national level and promotion of locality based targets is required. Identification of and information on identified savings is required along with the sharing of best practice. This could be supported by benchmarking with similar areas of the country.

Health promotion is embedded into all of our communities and some of the messages have been very successful i.e. five a day etc. However, despite this success health inequalities are still rising. There are two possible contributing factors to this:

1. As we complete more research and gather more evidence public health messages can become contradictory and people can become confused by the right thing to do (e.g. MMR vaccinations).

2. Often health improvement services are offered to the whole population, whereas there is enough evidence to suggest that if these services concentrated on the most vulnerable people they would have a greater impact on the overall health inequalities of the population.

This is very simplistic answer to an issue that has many more contributing determinants on health, however, if we can address the two points above it will start to help people's health and wellbeing in our local communities.

We need to stop thinking about prevention and early intervention as a separate issue and integrate it into practice at all levels.

Good outcomes can be patient defined, patient experience, improved reported quality of life, reduced need for health intervention, reduced admission to hospital. Good outcomes in prevention can only be achieved if the service and the service user clearly understand what they want to achieve at the outset of the process.

Clear prevention strategies that outline the difference between Primary, Secondary and Tertiary prevention for an individual are important. Also it is important for all services to remember that people still have prevention needs even if they have complex health needs. For example a person who moves into a residential care home due to ill health might still want to go to church every Sunday, by not facilitating these services could risk affecting the individual's emotional well-being.

Commission for public health outcomes rather than units of ill health treatment. However, there is an argument for more outcomes focussed on the actual needs of the community rather than the general public health message which may improve ability to engage with self care and earlier access to advice. Pump priming some projects within communities that could then be used to demonstrate to others that things can be achieved through different means.

There needs to be a range of mechanisms that target whole populations at different levels and then at specific groups to individual levels. Promotion of health should be everybody's work.

There needs to be a lifting of the scrutiny that the public sector is under. If you want to produce a culture of innovation this is often carried out with an element of risk. This risk firstly needs to be accepted and then properly managed. With the current economic restrictions there is added scrutiny from the public. The attached news report shows an innovative solution that not only is supported by patients, but saves money, yet the Hospital in question is forced to defend itself under public scrutiny.

http://www.bbc.co.uk/news/uk-england-london-11708963

5. What are the priorities for creating a more diverse and responsive care market?

The Social Care market would be defined as the range of providers of social care components of care packages, which could be individuals, groups or organisations, and be statutory, voluntary, private or informal and increasingly involves other services not traditionally viewed as social care but clearly deliver a social care function (e.g. libraries).

Whilst client group is relevant, level of need is a continuum and the market needs appropriate skill sets to be able to respond to a range of need whether it is for an older person or younger adult.

What is clear is that assumptions about the social care market are going to change in the coming years. Key trends include greater choice and control over service provision for users and carers, a stronger emphasis on communities / prevention and changes in the basis of funding care.

In the long term, the market for social care is likely to expand (based on the demographic growth of the population combined with a continuing period of morbidity prior to death) with a greater number of self funders of both care and health services due to a diminution of state funding combined with greater pensioner wealth.

Growth in the numbers of older people will drive a change in attitudes and services towards older people - There will be an increased development of older people-friendly housing and also shops and community facilities being made more accessible to older people. These initiatives are likely to be driven by greater numbers of older people combined with higher levels of disposable income and property amongst the over 65 population.

A greater number of older people will control their care funding - In some ways this is inevitable if there is a growth in population and a growth in wealth and equity amongst the older person's population. This will also occur through a greater emphasis on the use of personal budgets by central and local government together with a retraction in local authority expenditure. What is less clear is the financial impact of people with a learning disability outliving their parents and what happens to the disposal of those people's estates.

There will be changes in the home care market as more diverse roles are expected from home care providers - The home care market is still very diverse with a large number of small providers. This is likely to continue as long as the home care function remains relatively discreet and with low entry barriers. However, if greater expectations are placed on home care services to deliver more complex interventions at the health and social care interface then this may result in changes including higher entry barriers. This may lead to changes in business models, including perhaps the consolidation of some providers, and increased specialisation by others. Diversification and increased demand due to population growth may also bring new players into this sector. All home care providers may be squeezed by greater use of unregulated support including personal assistants.

The care home market will continue to consolidate and care homes will get larger - The care home market is still the sector most likely to attract large scale providers. There is an impression that the average size of care homes is continuing to increase (mainly driven by economies of scale). Competition between large care providers is likely to increase as the number of potential customers, grows. More direct marketing to service users is likely to be a feature.

There will be a continuing reduction in the role of local authorities as direct providers of care - Despite the move from the 1980's onwards for local authorities to divest themselves of in-house provision, in some areas they are still significant providers. All indications are that local authorities will continue to reduce this commitment in the future. For example residential care home places in council run homes fell by over 7,000 between 2004 and 2008 and this trend was mirrored in Halton. However, the overall size of the market remained relatively static.

The next generation of older people is likely to take a wider view of where they spend their final years - This current generation of older people is far more used to, and accepting of, overseas travel and hence prepared to seek cheaper retirement accommodation outside the UK. Such a trend has been encouraged in recent years both by an increasing supply of care and retirement accommodation in Europe, particularly Spain. Continuance of this trend may depend on price vs. location combined with older people still being able to access UK benefits whilst living abroad.

These trends, as outlined in Transforming Social Care and Putting People First, are likely to involve a changed relationship between local authorities and the social care market. Authorities have already moved from being primary providers of care to roles as commissioners and purchasers. What will this

mean for the financial viability for the services currently delivered by the Local Authority ?This move from direct involvement in front line care is likely to be further encouraged by local authorities seeing one of their primary tasks as being able to facilitate and develop the care market; ensuring an appropriate range of services are available (regardless of whether care is being purchased by self funders, personal budget holders or by the Local Authority on their behalf), without the reliance on direct purchasing power that has been the case in recent times.

A robust Joint Strategic Needs Assessment (JSNA) needs to be in place alongside published commissioning intentions to inform market development. The JSNA should not just be a series of data and needs to be based around the health questions and priorities that need to be addressed locally. For example, what is being done locally for people who have survived a stroke (a major health issue in Halton)? This shifts the data from just counting numbers to looking at trends. This is important as there is a subtle difference between the number of people who have had a stroke in a geographical area compared to the incidence of stroke in the last 12 months.

Health and Wellbeing Boards must be central in influencing the social care market and also other strategic partnerships which influence factors that are the wider determinants of heath such as employment, housing and community development.

In managing the Social Care market improved information, training, support and advice to providers and commissioners is required. Greater understanding of needs and current best practice methods of person centred support by providers, whether in residential or community settings, would shift focus away from 'specialist' providers, increase supply, improve quality of outcomes and offer greater choice for both local authority and individual commissioners.

Telehealth and telecare, improvements in domiciliary, residential and nursing home practice and changes in housing with care need to form the basis of future interventions. Local Authorities and partners will need to take an evidence informed view of the areas where they need to invest in the future.

The overriding considerations in assessing the market are quality and cost effectiveness. The care market is not protected from market forces - as financial crises for a range of providers has recently demonstrated. As part of the provider registration process there should be an assessment of business viability and Care Quality Commission (CQC) are best placed to co-ordinate this and review as part of its ongoing monitoring and inspection regime. Publication of this information could be detrimental to the continuity of a struggling enterprise but could be used as an alert by CQC and/or local authorities that there is a problem with the provider and this may pose a threat to continuity of care.

If local authorities and service users are to get consistent, viable services that reflect peoples changing expectations then there is a need to carefully consider the balance in relationships between service users, the local authority and the social care market. This can be further developed by the

increasing power for GPs. The market has to understand that GPs operate as a business and with this comes all of the normal risks of a failing organisation, but with the increased risk to patients if this happens.

Individual purchasing through direct payments could have a positive impact in driving up quality and encouraging smaller providers into the market place. However it may also reduce provider's economies of scale and increases risk of sustainability as there are no guarantees of business through block contracts. For a range of small providers viability, quality and performance may be an issue if standards are to be met. The market could respond to this additional risk by increasing prices for personal budget holders. At this time there is limited evidence that quality in outcomes is increasing proportionate to increased price. Over time this may level out as consumer choice dictates which providers in the market they value and those that should leave.

Self directed support may fragment the market and make it more difficult for Authorities to manage the market, leading to issues of service quality, safeguarding and cost effectiveness. Market fragmentation risks a failure to attract and develop the right people with the right skills and ensuring they are retained in the system.

All providers within the care market should have monitoring measures in place and there would need to be contingency arrangements for provider failure to ensure individual's care packages do not collapse. There should also be arrangements for reviewing performance, learning lessons from failure and undertaking processes to transfer learning to quickly introduce revisions.

6. What role could the financial services market play in supporting users, carers and their families?

There is a culture change required to make clear from early on in people's lives that there may be a compulsory requirement to fund elements of care later in life.

There is a lack of clarity about the risk element individual users would be undertaking. Advice and support needs be delivered to help people understand this and the options available to them. The financial services sector will have a role in this but are there other organisations that may be better placed – such as Local HealthWatch? The advice and support would need to be impartial.

Any system with nationally consistent eligibility criteria, portability of assessments and a more objective assessment would need to have robust reassessment and review procedures to ensure both need is met and finance is used in the most effective and efficient way. It could be argued that a consistent approach contradicts the concept of personalisation. A national standard criteria would be useful for professionals, but not always helpful for service users.

Questions about what wider roles could the financial services industry play may be best directed towards the financial services sector.

7. Do you have any other comments on social care reform, including the recommendations of the Commission on Funding of Care and Support?

There is no doubt that the elements of integration are welcomed, however as explained in some of the previous answers it is challenging to carry out successful integration etc with the financial backdrop we are currently working in.

For example, the adult social care departments (in England) have been reducing their budgets in 2011/12 by £1billion in response to the overall reductions in public spending and that this pace of reductions is likely to continue over the current spending review period. A full analysis of the budget pressures experienced by Adult Social Care is captured in the ADASS Budget Survey 2011 Analysis. It is believed that this current funding will lead to efficiencies being required in the self directed support services and will put a strain on the policy underpinning the personalisation agenda. Is it going to be affordable? The journey started four years ago within a different context and financial climate. The need to achieve savings over very short time scales presents risks that really need to be understood and mitigated against. Also it is about managing expectations and reinforcing the citizenship/responsibility element of the Coalition's Government for Adult Social Care as set out in their November 2010 vision.

It would prove useful if more comprehensive guidance on "deliberate" deprivation of assets to avoid future charges was made available along with future guidance on charges for services when considering the changes that will take place when the White Paper is implemented.

Consideration needs to be given to the impact that wider social/welfare reform and associated policy changes will have on the provision of Adult social care as a whole for example what will the impact of the localisation of council tax benefits have? Will the Government be considering this and other policy changes in terms of the impact they will have, prior to publication of the White Paper and update report on Funding Reform?

Further consideration also needs to be given to the role that providers of low level activities and services provided to promote health and wellbeing, have in reducing the spend on more intensive services.