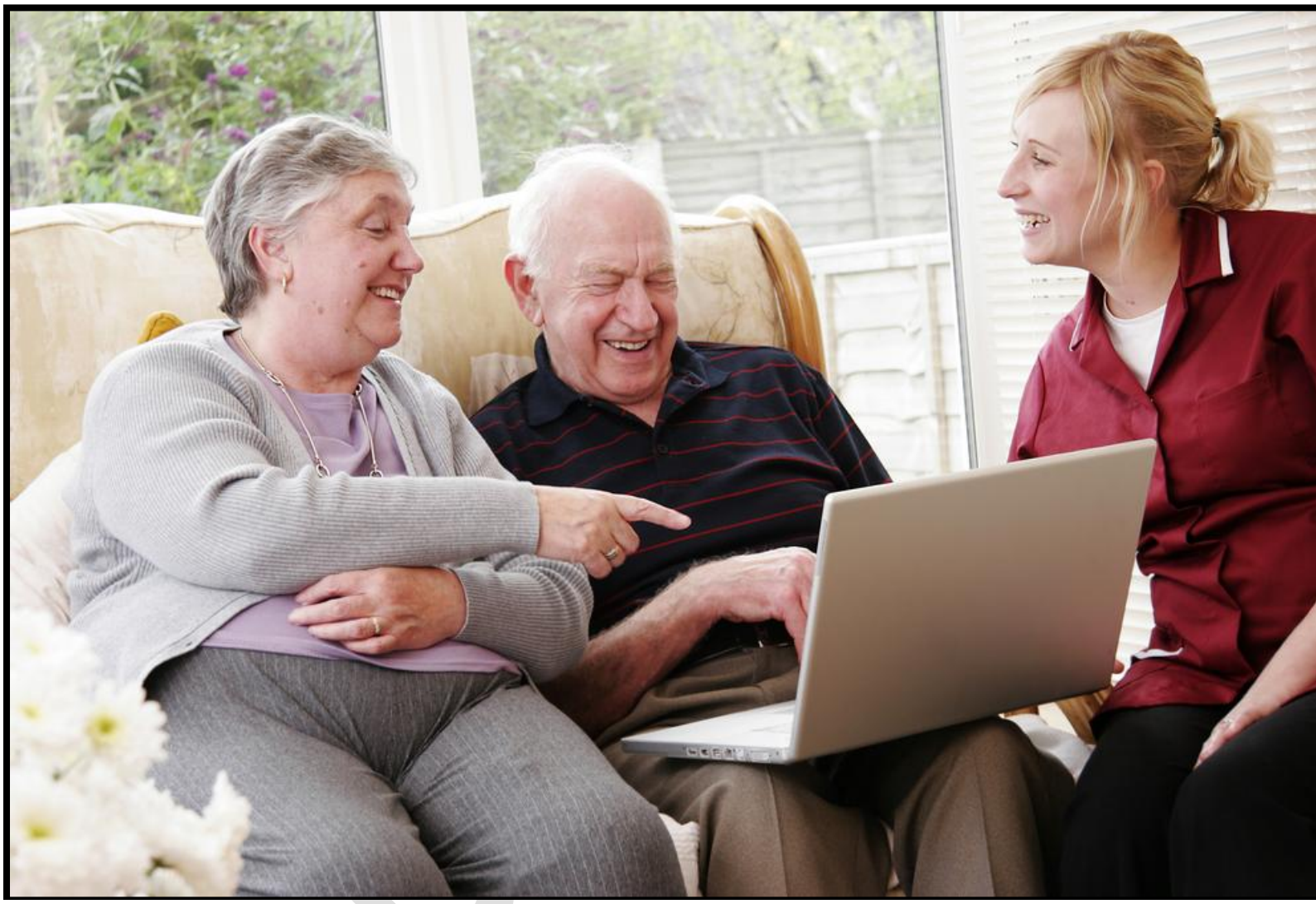
Overview and Scrutiny Review

Adult Social Care Scrutiny Committee

November 2011 – May 2012



Residential Provision Review

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1.0 Foreword

Councillor F Keegan – Chairman of the Task and Finish Group

1.1 The funding and provision of social care in England is widely acknowledged to be in need of reform, and over the past decade a variety of papers, committees and reports have made suggestions about the shape of the reform.

1.2 There are 3 major drivers of change. Firstly, the post war "baby boomers" are retiring and the over 65 group are estimated to grow in numbers by 60% over the next 20 years, whereas over the same period the working population will reduce by 7%. Secondly, the current and foreseeable economic climate will inhibit the funding growth in Adult Care budgets and the demand pool will grow at a much faster rate than the available resources. In large measure the current retirees are less well funded than previous retirees and it should be expected that the profile of those dependent on Council Resources will widen dramatically. Thirdly, the Judiciary is beginning to rule that the lack of Resources is not a good enough reason to withdraw or curtail services. In summary, a substantially larger pool of people, less well funded than previously, can expect legal backing to have their assessed needs met and the working taxpayer base will have shrunk by 7%.

1.3 The aim of this review was to explore how the life experiences of older residents in Cheshire East could be enhanced. The overwhelming desire of residents is to be self sufficient in their own homes, either independently or assisted with carer's, and the Group support that as the ideal solution for all.

1.4 It is certain that 'business as usual' will result in a serious collapse of the care system at some point in the near future, and so the Group favours an alternative approach, mindful of the fact that there are no brand new solutions. In conjunction with the new approach, the Group recommends an aggressive switch to 'Invest to Save', which will have 2 impacts; firstly it will switch expenditure from Revenue to Capital and secondly it will enable residents to live longer in their own homes. The touchstone has to be that the electorate assume personal responsibility for their own care and the role of the Council is to make that personal responsibility a reality.

1.5 This report is the summary of discussions between Councillors with a genuine interest in the subject matter and I would like to thank Councillors Janet Jackson, Laura Jeuda, Irene Faseyi and Shirley Jones for their time, diligence and hard work in shaping this

report. We acknowledge the invaluable work done by Mark Grimshaw who shepherded the discussions into an agreeable report. The group members would also like to thank all the witnesses who gave evidence to the review. A full list of witnesses is given in the body of the report.

1.6 We commend this report to Cabinet.

Front cover picture extracted from:
http://ec.europa.eu/employment_social/emplweb/families/index.cfm?langId=en&id=3&news_id=1221&news_det=yes

2.0 Executive Summary

2.1 The care and wellbeing system that has supported the country since the Social Welfare Legislation of 1943 has relied on "a certain balance between demand and resources, between formal and informal care, between prevention and acute care and between numbers of older people and those of a working age."[1]

2.2 This balance has reached a tipping point. Indeed, given the massive scale of the challenges that the adult social care system faces in terms of increased demand (both in number and complexity), reduced budgets, higher expectations from service users and a private care market in turmoil, it is clear that continuing with a 'business as usual' approach is both unfeasible and unsustainable.

2.3 This review asserts therefore that a new, radical approach to adult social care is required to manage cost and demand without allowing standards to fall. There is not one single solution to this situation; the complexity of the issue negates this. There is however, an opportunity to explore a strategic approach which redirects and shifts the balance of funding, where appropriate, from acute residential care towards an integrated and community based approach with 'prevention' at its core.

2.4 Indeed, the Group has been influenced by Maslow's Hierarchy of Need (see p.24) as a model for looking holistically at all the needs of a service user within their family and community and the Danish[2] model of social care which places the community at the centre of care delivery. It is believed that social care can no longer exist as a separate entity, hidden out of sight in a care home but rather it should be aligned and entwined with all aspects of social policy and wider society.

2.5 The Group feels that the policy direction and mitigation strategies set out in this report will help to contribute to such a change in approach. It is hoped that the work in this review will also sit alongside and contribute to the Ageing Well Programme – the principles of which are fully endorsed by the Group.

2.6 The RECOMMENDATIONS of the review are as follows:

2.7 <u>Strategic</u>

2.8 The Group does not claim to have all the answers to the considerable issues facing adult social care but it does feel that helping to facilitate older people to stay safely in their own homes whilst retaining an active role in their own communities is the best way forward. What follows are a set of strategic recommendations that the Group feels will help the Council and its partners towards achieving such a principle.

[1] 'The Case for Tomorrow – A joint discussion document on the future of services for older people' ADASS p.9

[2] 'Home- and Community-Based Long-Term Care: Lessons from Denmark', M. Stuart and M. Weinrich, *The Gerontologist*, 41(4), 2001: 474–80; and 'Housing and Service for the Elderly in Denmark', B. Lindstrom, *Ageing International,* 23, 1997: 115–32

2.8.1 That the Council agree to the principle of changing strategic direction in order to alter the focus of how the Council funds social care. This would involve incrementally shifting funding from acute high end care towards facilitating more preventative community based and delivered care.

2.8.2 That the Council, working with partners from Health and the Voluntary and Community Sector agree to pilot a 'social care hub', akin to the Danish model. The focus of this hub would be to co-ordinate and facilitate the preventative mitigation strategies outlined in the report and to ensure that all aspects of social policy are aligned for older people, particularly housing (planning) and transport. That the performance and impact of the 'hub' be monitored closely.

2.8.3 That the Cheshire East Health and Wellbeing Board, when fully formed and operational, make integrated working a top priority and that they monitor the transition between the outgoing CECPCT and the incoming Clinical Commissioning Group (CCG) to ensure that existing integrated practice is not lost.

2.8.4 That the Cheshire East Health and Wellbeing Board facilitate conversations between the Council, CCGs and the Voluntary and Community Sector so that integrated long term and sustainable strategies and funding structures can be implemented.

2.8.5 That the Council explore funding additional sheltered housing/extra care housing placements that are affordable (for the individual and the Council) and embedded in the community. That particular attention is paid to a need for such housing in the North of the Borough (see p.29).

2.8.6 That the Council seek to open a dialogue with private care home owners regarding the self funding market in order to foster a positive and mutual working relationship. This would aim to facilitate:

i. Private Care Homes flagging up the Council when an individual has presented for care so that intelligence can be gathered as to the potential size and characteristics of the self funders market.

ii. Private Care Homes referring an individual to the Council for independent financial advice in managing their resources both when they present for care and when they are already in receipt of care with depleting resources.

2.8.7 That when the Council makes a budgetary proposal, joined-up systems are put in place to ensure that full and proper consideration is given to the potential ramifications on other functions of the Council.

2.9 Operational (thematic)

2.10 During the evidence gathering process, the Group encountered a number of examples of good practice. What follows therefore are a number of recommendations that the Group believe will enhance this work.

2.10.1 Housing

i. That the Council explore putting more money into the housing financial assistance policy (beyond the £1.4 million already identified) and the discretionary loan funding budgets. This could be funded through capital borrowing as it is felt that the savings created in the revenue budget (by preventing people entering care) would more than offset the cost of borrowing.

ii. That the Council explore helping residents to rent out their home so that the rental income could be used to offset care costs whilst maintaining a capital asset for the family. That this be considered alongside the Council's empty property lease scheme (in development).

2.10.2 Improving Older People's Transport

i. That the Council target those older people with a Higher Mobility Allowance to get them to use it towards transport so that they maximise their income and that costs are reduced for the Council.

2.10.3 Managing the Market (Self Funders)

i. To help foster positive relationships with private care homes, that the Council reduce care home administration costs by improving the efficiency of the payment process

ii. That the Council ensures that customer facing staff are recording all contacts (and providing people with accessible, accurate and appropriate information and advice) so that the Council can monitor the current self defined needs of self-funders and the nature of these contacts.

iii. That the Council improves the basic advice and information given to self funders so that it goes beyond simply a list of care homes by including good quality independent financial advice and information on alternate accommodation solutions such as home improvement grants and extra care housing.

iv. That the Council look to establish an extensive media campaign to try and get people of all ages but particularly those 50+ thinking about how they will fund their future care.

v. That the Council explore providing an annuity product that would help people to provide for their care in old age.

vi. That the Council ensure that the deferred charge scheme is robust by firstly establishing a framework for when people have to liquidate an asset in order to pay off a deferred charge agreement and secondly ensuring that people sign up to the agreement before it is granted.

v.iii. That the Council work with appropriate providers to possibly joint fund a welfare advisor in order to ensure that people are receiving the benefits to which they are entitled.

ix. That the Council explore commissioning a piece of research, perhaps in conjunction with a local university, to map the number and characteristics of self funders in Cheshire East.

2.10.4 Caring for those who care

i. That the Adult Social Care Scrutiny Committee receive a series of reports detailing the various areas of pressure in terms of carers.

ii. That the Council increase the Carers' Steering Team resource to 3FTE at an approximate cost of £61,900pa to deal with the future demands of the service.
iii. That the Council explore funding a pilot to commission externally its carer assessment process using Trafford Council as a model.
iv. That the Council explore standardising the collation of carer information across all Voluntary, Community and Faith sector partners who support carers.
v. That the personal budget pilot for carers be extended across the Borough
vi. That the Council work with third sector partners to improve their assessment processes so that capacity is not used unnecessarily.

3.0 Outline of Review

3.1 Background

3.2 At the meeting of the Council on 21 April 2011 a Notice of Motion had been submitted by Councillors D Flude and C Thorley regarding instability in the residential care market in Cheshire East and its potential impact on the finances of the Council. It was requested that a Scrutiny Committee Task and Finish Group be set up to determine the best means of managing demand for residential care including demand from returning self funders.

The Council resolved:

That the matter be referred to the Adult Social Care Scrutiny Committee with a view to them examining the matter and reporting back on:

- The stability of the residential care market in Cheshire East
- The availability of residential care at affordable prices in Cheshire East
- The success or otherwise of current measures to manage the demand for residential care in Cheshire East.
- The success or otherwise of measures to support self funders to remain independent of Council funding for longer

In a meeting of the Adult Social Care Scrutiny Committee on 22 September 2011, it was agreed to establish a Task and Finish Group to explore the issues raised in the Notice of Motion.

3.3 Membership

3.4 The Members of the Task and Finish Group were:

Councillor Frank Keegan (Chairman)
Councillor Laura Jeuda
Councillor Janet Jackson
Councillor Irene Faseyi
Councillor Shirley Jones

3.5 Terms of Reference

- To construct a detailed picture of the demographics in Cheshire East to fully understand the potential demands on services now and in the future.
- To understand the success or otherwise of current measures to manage the demand for residential care in Cheshire East.
- To explore and then recommend some credible policy options for mitigating demand and pressure on Cheshire East, the NHS and the voluntary sector, particularly with regard to returning 'self funders'.
- To explore the best way for Cheshire East to ensure a mixed and therefore stable residential care market that is affordable and of good quality.

3.6 Methodology

3.7 Witnesses:

Members met with the following people during the review:

- Councillor Dorothy Flude (attending as a witness)
- Lucia Scally - Head of Strategic Commissioning and Safeguarding
- Liz Austin - Strategic Commissioning Manager
- Lyn Glendenning - Commissioning Manager (SP and Contracts)
- Bernadette Bailey - CECPCT Commissioning Manager
- Alison McCudden – Commissioning Manager, Income Maximisation.
- Karen Whitehead – Private Sector Housing Manager
- Sophie Middleton - Contract Manager - Extra Care Housing
- Beechmere Extra Care Housing Residents
- Rob Walker – Commissioning Manager
- Libby Brookes – Project Officer, Carers Team
- Helen Clark – Project Officer, Carers Team
- Residents of Beechmere Extra Care Housing Scheme
- Councillor Roland Domleo – Portfolio Holder for Adult Services
- Adrian Lindop – Chairman of the Crewe and Nantwich Seniors Voice Group
- Dominic Anderson - Policy and Development Manager Age UK Cheshire East
- Councillor Don Stockton (attending as a witness)
- Graham Wood – Dial-a-ride Joint Co-ordinator
- Bill Scragg – Dial-a-ride Chairman
- Lorraine Butcher – Strategic Director of Children, Families and Adults
- Jacqui Evans - Head of Local Delivery/Independent Living Services
- Councillor Janet Clowes – Portfolio Holder, Health and Wellbeing

3.8 Timeline:

Date	Meeting / Site Visit
9 November 2011	Initial scoping meeting • Councillor Dorothy Flude (attending as a witness) • Lucia Scally - Head of Strategic Commissioning and Safeguarding • Liz Austin - Strategic Commissioning Manager • Lyn Glendenning - Commissioning Manager (SP and Contracts)
5 December 2011	Scoping and background information • Liz Austin - Strategic Commissioning Manager • Lyn Glendenning - Commissioning Manager (SP and Contracts)
16 January 2012	Background to the Ageing Well Programme • Liz Austin - Strategic Commissioning Manager • Bernadette Bailey - CECPCT Commissioning Manager

31 January 2012	Discussion over self funder issue and current strategies to provide timely financial advice • Alison McCudden – Commissioning Manager, Income Maximisation.
20 February 2012	Discussion over extra care housing and home improvement policies. • Lyn Glendenning - Commissioning Manager (SP and Contracts) • Karen Whitehead – Private Sector Housing Manager
5 March 2012	Tour of Beechmere Extra Care Housing Scheme and conversation with residents • Sophie Middleton - Contract Manager - Extra Care Housing Discussion over carers • Rob Walker – Commissioning Manager • Libby Brookes – Project Officer, Carers Team • Helen Clark – Project Officer, Carers Team
14 March 2012	LGA Smith Squared Debate – 'Social Care is an Embarrassment'
19 March 2012	Discussion over dial-a-ride and extra care housing • Councillor Roland Domleo – Portfolio Holder for Adult Services • Adrian Lindop – Chairman of the Crewe and Nantwich Seniors Voice Group
2 April 2012	Discussion to gain Third Sector Perspective • Dominic Anderson - Policy and Development Manager Age UK Cheshire East
16 April 2012	Discussion regarding the private care market and dial-a-ride • Councillor Don Stockton (attending as a witness) • Graham Wood – Dial-a-ride Joint Co-ordinator • Bill Scragg – Dial-a-ride Chairman
15 May 2012	Consideration of 1st draft
7 June 2012	2nd draft considered by informal Adult Social Care Scrutiny Committee
11 June 2012	Consideration of 2nd draft
21 June 2012	3rd draft discussed with Lorraine Butcher, Lucia Scally, Jacqui Evans and Councillor Janet Clowes
5 July 2012	Final draft considered by Adult Social Care Scrutiny Committee

4.0 Review Findings

4.1 Introduction

4.2 Ageing is a basic condition of human life, a fact that all societies have to accept, but as Evans (1998)[3] suggests;

"Our hope is to spend a long time living and a short time dying. There are grounds for believing that we can increase the proportion of individuals who achieve this, and this ideal should be the focus of research on human ageing"

4.3 Whilst accepting the principle, the challenge to achieve this for most European societies is becoming increasingly difficult. A century ago it could not be taken for granted that a newborn would reach old age. Indeed, a person living in the industrial age would frequently be at serious risk of terminal illness, with poor educational access and a working day that was longer and often physical. Older people of today and tomorrow will have experienced better schooling/health services and a later entry into the labour market with drastically different working conditions and retirement rules. All of which has led and will lead to new cohorts who experience and will experience decades of life after retirement.

4.4 This is undoubtedly a positive and progressive development – fulfilling the hope that people spend a long time living. However, it has also led to a significant and rapid change in the age composition of society bringing with it a number of challenges. These can be summarised as thus:

- As there will be will fewer people of working age to support retirees will the large numbers of older people bankrupt a health care and social security system already experiencing funding pressures?
- Polarization is to be expected between more 'young old' people in better health than similar age groups are now – and a small proportion of frail 'older olds'. The fraction of 'older olds', however, will be bigger than now, older than now and therefore frailer than most older people are today with increasingly complex (and costlier) needs. In other words, there is an ever increasing fraction of people who are spending a long time dying.

4.5 It is clear that there is a need for adaptations at individual, social and societal levels to cope with such challenges and to develop a sustainable social care system. Such a system would look to help people remain active and healthy as they age – reducing demand on heavy institutional care which is neither desirable nor affordable for individuals and social care commissioners. It was from this principle that the Group began their research to explore how the Council could achieve such a sustainable system.

[3] Evans JG, (1998b): Innovative research and appropriate health care for the citizens of Europe. Parallel Session B. Ageing: Synonymous with disease and disability. Proceedings of the invitational conference on the occasion of the Netherlands' EU Presidency. European Commission EUR 17786 EN. p. 52-61

5.0 Policy Context

5.1 National

5.2 The funding and provision of social care in England is widely acknowledged to be in need of reform, and over the past decade a variety of papers, committees and reports have made suggestions for what reform should look like. Probably the most widely reported of these is the Dilnot Review, otherwise known as 'Fairer Care Funding' published by the Commission on Funding of Care and Support in July 2011.

5.3 This asserted that "The current adult social care funding system in England is not fit for purpose and needs urgent and lasting reform" and suggested that a "major problem is that people are unable to protect themselves against very high care costs." As a result, the review recommended that there needed to be a fairer way of sharing costs and responsibility between the state and individuals and a cap of £35,000 for care contributions was put forward.

5.4 Representatives of the Group also attended an LGA conference on the 14 March 2012 which involved a debate between various social care professionals on the assertion made by Andrew Dilnot that 'Social Care [in the UK] is an embarrassment'. The Chairman of the debate, Councillor David Rogers, provided a useful summary of the national policy context in his opening remarks. He asserted that for decade's central government had grappled with the issue of adult social care and support reform. He noted that different governments had put forward ideas on exactly how this should be done, but they had only achieved minor tangible changes or worse, stalled completely. He commented that it was hard to pinpoint why wholesale reform had never fully succeeded although he noted that a combination of political inertia, public indifference and concern over associated costs were probably to blame.

5.5 Councillor David Rogers continued to assert that he believed that the conditions for wholesale reform were now favourable with the public and policy makers alike and called on the imminent white paper on social care to make good on this momentum. As an aside, he called on the Bill to recognise the importance of local government and to make sure that the governance architecture for social care fostered the desirable changes.

5.6 The other speakers at the debate were as follows:

Victoria Hart – Social Worker, Camden and Islington NHS Foundation Trust
Caroline Abrahams – Director of External Affairs, Age UK
Matthew Young – Founder and Director, Public Policy Projects

5.7 They identified the following themes as priorities:

- Better interagency working between health and social care – agreed that Health and Wellbeing Boards (HWBs) would have a vital role to play in achieving this. There was a particular concern that the integration achieved by the outgoing PCTs would be lost in the transition to Clinical Commissioning Groups (CCGs) and it was hoped that the HWBs would monitor this closely.
- Transparent charging structures on a regional basis
- More money in the system
- More user voices and advocacy required
- Quality and reach of care needs to be addressed as a priority.

5.8 Local Policy Context

5.9 The Group was pleased to note that the Council and its partners have recognised that due to a decrease in funding and an increase in demand there is a need to start doing things differently to prevent social care provision dropping to an unsatisfactory level. This recognition has resulted in the **Ageing Well Programme –** a result of 18 months work between a number of partners to agree a set of priorities for the future of social care provision.

5.10 Expanding on what would be done 'differently', the Group was informed by the CECPCT Commissioning Manager that the focus of the Ageing Well Programme would be on preventative services. It was noted that traditionally the Council/NHS commissioned services such as care homes that residents didn't really want. It was explained to the Group that the programme would attempt to get stakeholders to agree to increasingly move resources into preventative services so that a) outcomes would improve for the resident and b) demand would be reduced on services – improving their sustainability and at the very least maintaining their quality.

5.11 The work of the Ageing Well Programme will be focused into the following work streams:

1) Housing and Transport
2) Community Safety
3) Income/Employment
4) Adult Learning
5) Care and Support
6) Communications and Engagement.

5.12 All of these work streams have their own vision and priorities and they are tailored to firstly individuals in the 3 stages of later life (1. Preparing Well, 2. Living Well, 3. In receipt of care and support) and secondly to the respective communities in which said individuals reside. An overarching aim of all these work streams is to try and help people and communities to remain healthy for longer so that they do not have to come into contact with social care services until absolutely necessary.

6.0 Local Areas of Pressure

6.1 Demographics

6.2 Robust demographic data, covering both the absolute numbers of older people and the proportion of older people relative to those of working age, are essential for formulating social care policy.

6.3 The following demographic information has been taken from the Office of National Statistics (ONS) and in particular the 2009 Registrar General's Mid Year Estimates (MYE). This is Crown Copyright material and it has been reproduced in this report with the permission of the Controller of Her Majesty's Stationary Office (HMSO).

Key Points

- Total population forecast to increase by 21,300 to around 384,000 by 2029
- 4% less children (aged 0-15) by 2029
- Workforce will continue to age until 2020
- Population aged 65 or above will increase by over 50%
- Those aged 85 or above will more than double to over 20,000 by 2029.

6.4 *Total population*

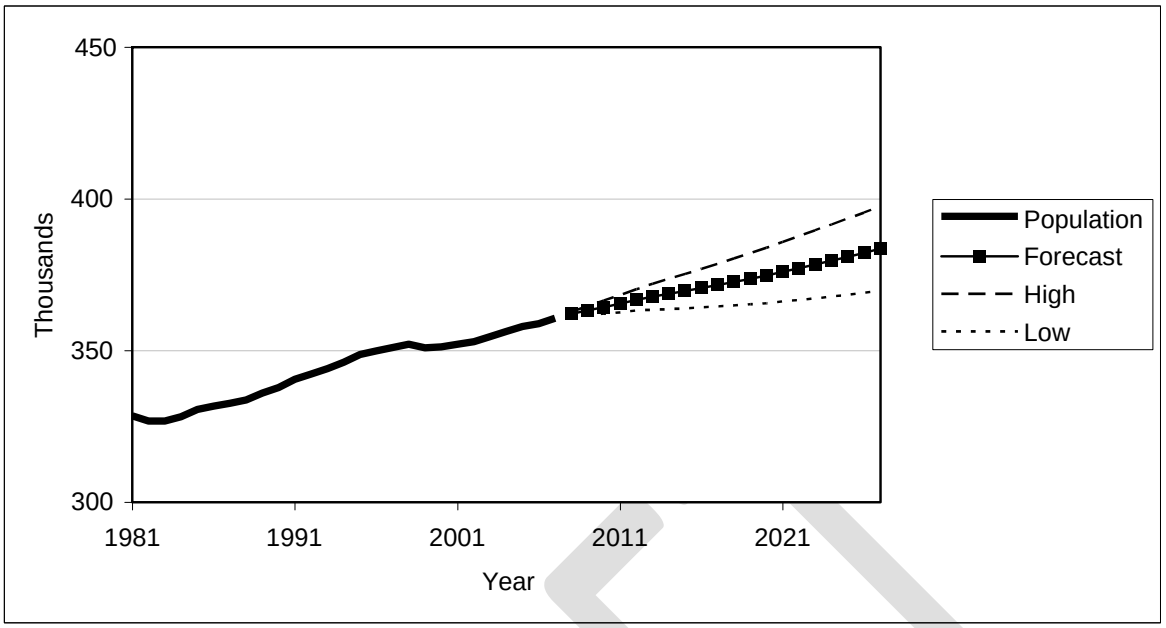
6.5 The number of people living in Cheshire East has, in general, shown a modest growth over the past 30 years. The population in 2009 was 362,700. This is expected to increase to 384,000 by 2029. This would continue the steady growth seen in the past. Forecasts based on alternative assumptions indicate the population could be as high as 396,700 or as low as 371,300.

Table 1: Total Population

	2009	**2014**	**2019**	**2024**	**2029**
Population (thousands)	362.7	365.8	369.8	376.5	384.0

Chart 1: Total population

6% increase in total population by 2029



6.6 The following charts show how the age structure of the population will change over the next twenty years. Much of these changes are simply due to the current population being older in 2029 than they are now.

Chart 2: Age structure 2009

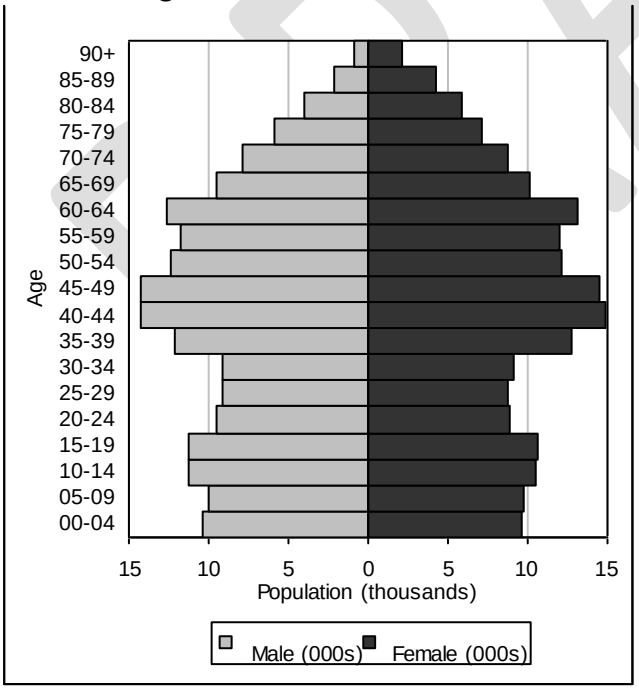
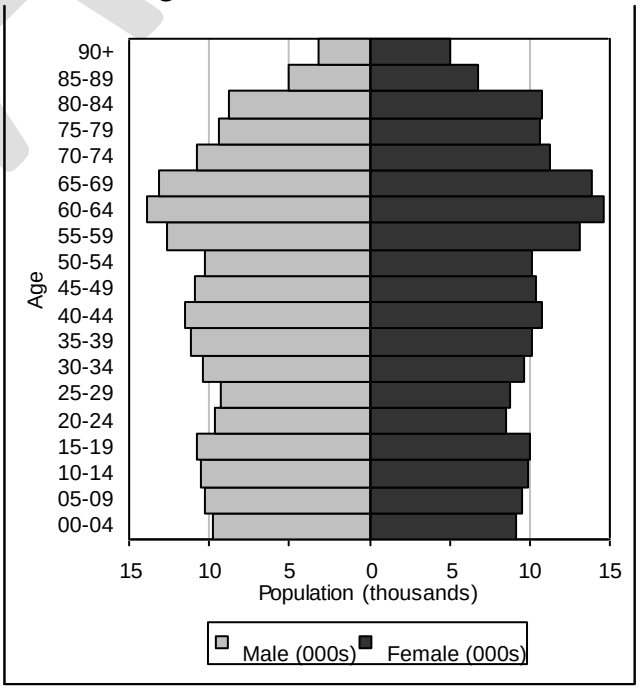


Chart 3: Age structure 2029

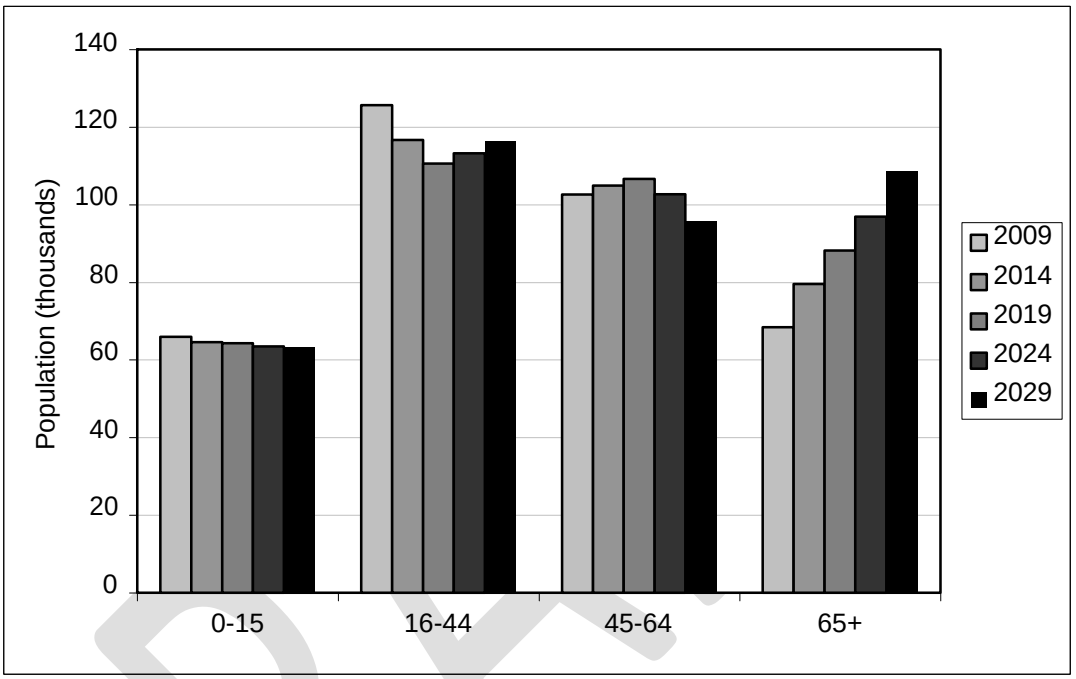


6.7 Older people will make up an increasing proportion of the population, as the number of people aged 65 or above significantly increases throughout the next twenty years.

6.8 The number of children (aged 0-15) will decrease slightly over the next twenty years.

6.9 The working age population and resident labour supply will decrease over the next twenty years. There will continue to be increases in older workers and decreases in younger workers until 2020 when there will be a reversal in this trend.

Chart 4: Population trends of key age groups



Population aged 65+ will increase by over 50%.

Table 2: Population of key age groups

	Population (thousands)				
	2009	**2014**	**2019**	**2024**	**2029**
0-15	66.0	64.6	64.4	63.5	63.3
16-44	125.7	116.7	110.6	113.3	116.3
45-64	102.6	104.9	106.7	102.7	95.9
65+	68.4	79.6	88.2	97.0	108.5
Total	362.7	365.8	369.8	376.5	384.0

6.10 Working age population

6.11 The number of people of working age will decrease by 7% over the next twenty years. The trend of decreasing numbers of people of younger working age and increasing numbers of people of older working age will continue for around the next ten years. But around 2020 there will be a reversal in this trend and the number of people aged 16-44 will increase whilst the number aged 45-64 will decrease.

6.12 It is also worth noting that those people in the shrinking working age population will have added financial pressures such as substantial student loans which will reduce their ability to both save for their own retirement and support elderly relatives.

Chart 5: Trends in working age population

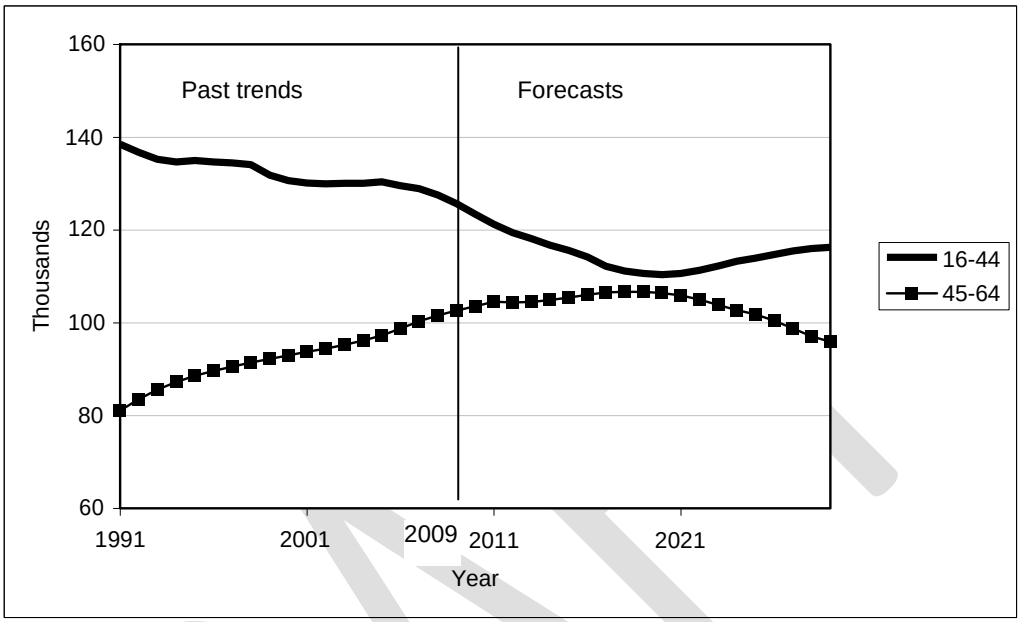


Table 3: Working age population

	Population (thousands)			% change	
	2009	**2019**	**2029**	**2009-19**	**2009-29**
16-44	125.7	110.6	116.3	-12%	-7%
45-64	102.6	106.7	95.9	4%	-7%
16-64	228.3	217.3	212.2	-5%	-7%

6.13 *Labour supply*

Labour supply = people aged 16-64 who are available for work

6.14 Changes in the resident labour supply will reflect the changes in the working age population. There will be a decrease in younger workers (aged 16-44) and an increase in older workers (aged 45-64) up to 2020. After this the number of older workers will decrease whilst numbers of younger workers increase.

6.15 The resident labour supply will decrease by around 6% over the next twenty years.

Workforce will continue to age until 2020.

Table 4: Resident labour supply

	Labour supply (thousands)			% change	
	2009	**2019**	**2029**	**2009-19**	**2009-29**
16-44	101.7	89.2	93.8	-12%	-8%
45-64	73.7	81.0	70.5	10%	-4%
16-64	175.4	170.2	164.3	-3%	-6%

6.17 Older People

6.18 This is the only age group forecast to have significant changes in size. The number of people aged 65 or above will increase by over 50% from 68,400 in 2009 to over 108,500 in 2029.

The number of people aged 85+ will more than double by 2029.

6.19 The number of people aged 85 or above will more than double over the next twenty years, increasing from around 9,300 in 2009 to over 20,000 in 2029.

Chart 6: Trends in Number of Older People

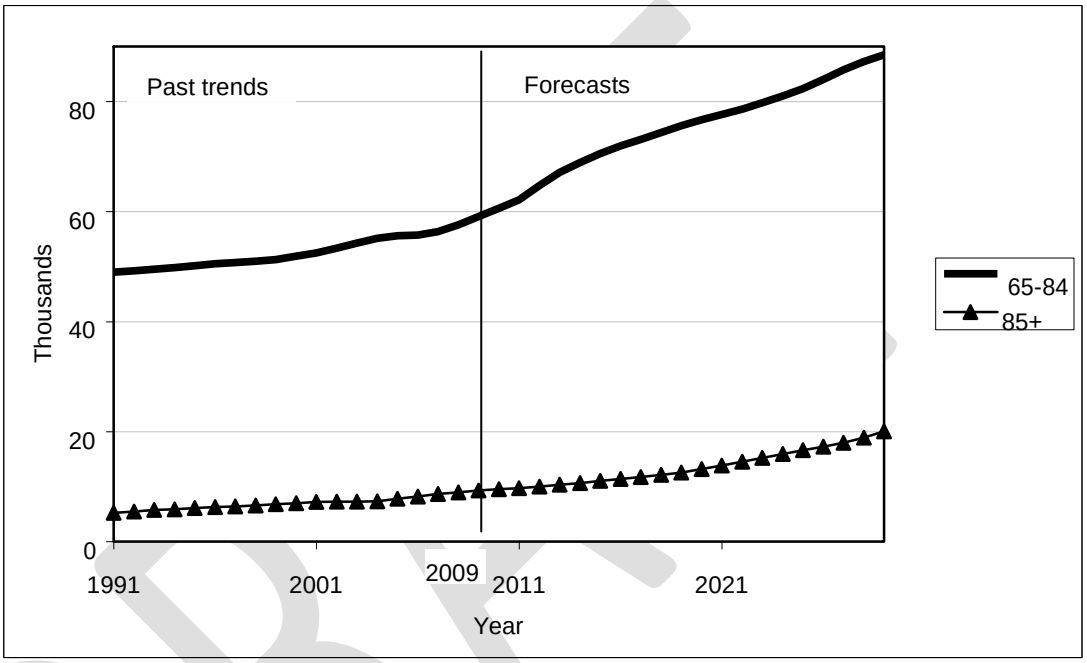


Table 5: Forecasts of Older People

	Population (thousands)			% change	
	2009	**2019**	**2029**	**2009-19**	**2009-29**
65-84	59.1	75.6	88.5	28%	50%
85+	9.3	12.6	20.1	35%	115%
65+	68.4	88.2	108.5	29%	59%

6.20 It is important to state that demographic projections are not bulletproof, but it is clear from this data that Cheshire East is likely to experience a sharp increase in both the numbers and proportion of pension-age individuals, and a relative reduction in the numbers of working-age people. Even if Office for National Statistics projections prove less accurate than in the past, the Borough can still expect to see large changes to the population over the next 25 years or so.

6.21 Whilst it is clear that there will be an increasingly older population in Cheshire East over the next 25 years, what is less apparent is the extent of the future demand for care. This will of course be dependent on the health of the cohorts of older people as they move through their lives. If people in their latter years are healthier than previous generations, demands for social care will rise less sharply than the size of the older population. If they are less healthy than their predecessors, on the other hand, the demand will accelerate.

6.22 Even if future cohorts live healthier lifestyles than their predecessors, the sheer number of people living to an age (85+) in which the need for complex care becomes highly likely will mean that demand for social care will increase. Society's ability to meet this demand is unclear and difficult to predict. The demographic picture, for example, is not one-sided. While the ratio of workers to older people will fall, the data above illustrates that fertility rates will remain low so will the proportion of children to working-age adults, thereby possibly mitigating the strain on public finances.

6.23 Having said this, the Local Government Association, in providing evidence to the Parliamentary Health Committee stated that "over the course of their retirement, men aged 65 today have a 7/10 chance of needing some care before they die, with a 9/10 likelihood for women. The best estimate of this demographic pressure—which both Councils and the Department of Health agree on—is 4% per year. The reality is therefore that if local authorities cannot achieve this additional 4%, then services will suffer—even before any funding cuts." Furthermore by 2026 the expectation is that there will be 1.7 million more adults who need care and support. This is a 30% increase on current numbers, which stands at around six million.[4]

6.24 Adult Social Care Budget

6.25 There is evidence that local and national circumstances has resulted in a variable impact on adult social care across the country. According to the Association of Directors of Adult Social Services (ADASS) the "average position appears to be that budgets will reduce by about 5% per annum over the next three years". The ADASS budget survey (2011) indicated that 150 English Authorities made a combined total of £1 billion savings in 2011-12, which was closer to 7% of the spend in the previous year.

6.26 There are added challenges for the Council as the population of Cheshire East is older than the average population of England. According to the Pre-Budget Report 2011/12 "Last year an allowance of £0.4m was made for this impact [of extra demand] and this has proved inadequate to meet the challenge especially for the 85 years and older age category on whom over £20m has been spent in care in the past year. The recessionary impact is also clearer,

[4] Building the National Care Service, HM Government, March 2010, p 48. Back

with falling house values and diminished personal savings causing greater costs to fall upon the Council. There is more reflection of this within the budget with an overall annual £4m of year on year growth provided (£11.8m covering the 3 years from 2009/2010 to 2011/2012)".

6.27 Whilst it is positive that the Council has recognised the need for added growth, this has been achieved through efficiency savings – many of which are one offs. There will obviously be a time when further efficiency savings cannot be made and therefore the Council will find it difficult to keep providing additional growth in the budget, regardless of demand.

6.28 Higher expectations

6.29 For those in need of social care the last few years has seen an increase in the individual's choice and control over services. There is now a clear expectation that people needing care will have greater choice and control but this brings with its own challenges for the Council as it tries to balance this expectation against increasingly limited resources.

6.30 Services and the Market

6.31 It is well recognised that a "thriving social care market with a range of providers"[5] is needed. However there are concerns across the sector about how this will be achieved. With the Council having frozen fees for two years, how services are best delivered within the context of limited resources is a real cause for concern.

6.32 Furthermore, "the collapse of Southern Cross is an example of the serious concerns about the capacity of the market to meet demand and deliver sustainable quality residential services."[6] This has been matched by the concern about the recently well documented cases of poor and undignified care provided by a number of residential services both nationally and in Cheshire East.[7]

6.33 Summary

6.34 The care and wellbeing system that has supported the country since the Social Welfare Legislation of 1943 has relied on "a certain balance between demand and resources, between formal and informal care, between prevention and acute care and between numbers of older people and those of a working age."[8]

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[5] http://davidbehan.dh.gov.uk/webchat-about-caring-for-our-future/

[6] 'The Case for Tomorrow – A joint discussion document on the future of services for older people' ADASS p.9

[7] http://www.cqc.org.uk/media/richard-dickinson-proprietor-care-home-knutsford-cheshire-has-had-his-registration-cancelled-a

[8] 'The Case for Tomorrow – A joint discussion document on the future of services for older people' ADASS p.9

6.35 It is clear from the challenges outlined above that continuing with a 'business as usual' approach is unfeasible and unsustainable. This Group asserts that a new, radical approach to adult social care is therefore required to manage cost, demand and expectations without allowing standards to fall.

7.0 Managing Demand – A Strategic Approach

7.1 Local government cannot call on many levers to manage demand, cost and efficiency and those that it can use are inevitably limited, and indeed in some cases self-defeating. Demand and cost are obviously closely linked although the relationship between the two is complex. First and foremost, packages of care are for real, individual people who have real, individual needs. For that simple reason it is not possible to neatly compartmentalise individuals into groups and groups into costs.

7.2 Furthermore, the common mitigation methods that the Council can call upon such as raising charges, stopping or closing services, reducing staffing levels and service budgets, and outsourcing—are difficult to pursue. The Council does not want to jeopardise outcomes for residents, which the aforementioned may do, and such activity is obviously hugely unappealing on a political level.

7.3 Very often the principal means of managing demand is to tighten eligibility criteria, which are used by Councils to determine whether a person qualifies for support. The eligibility framework is based on a person's needs and the associated risks to their independence. There are four eligibility bands: critical, substantial, moderate and low. The Group was made aware that the Council had already taken steps to improve their Fair Access to Care Criteria in order to reduce inequalities and inconsistencies.

7.4 According to the LGA[9], in 2009-10 roughly three quarters of Councils, including Cheshire East, set access to care at the 'substantial' level meaning individuals with 'substantial' or 'critical' needs would be eligible for Council support. Roughly one quarter of Councils set their access to 'moderate' and just a handful were at the extremes – either offering services to people just with 'critical' needs, or for those with 'low' needs and above.

7.5 It is not difficult to foresee a situation in which the Council, in a pressurised funding arena, might be tempted to set its eligibility criteria at 'critical' only. The difficulty with such an approach is that, whilst it may stem demand in the short term, the decrease in numbers presenting to councils will only be temporary as individuals' substantial/moderate needs escalate to the point of being 'critical'. This could likely mean a sudden increase in the more costly 'critical' end care packages.

7.6 It should be noted that the Council does not ignore those individuals who, following assessment, are deemed to fall outside the eligibility threshold. And indeed, putting in place services to **prevent** people entering the system in the first place is becoming an increasingly important Council strategy to manage demand.

[9] http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1583/1583we17.htm

8.0 'Invest to Save' – the Preventative Approach

8.1 A common theme throughout this review - from all those witnesses that have been interviewed – is that older people do not want (and in some cases, do not need) to spend so much time in hospital and in residential care. It seems clear therefore that the Council must increasingly look at ways and investment opportunities to stop people entering such acute care, unless it is entirely appropriate, as this will a) produce better outcomes for residents and b) help the Council to stretch its resources that little bit further. What follows is a series of findings and recommendations that the Group believe will help the Council go some way to achieving this.

8.2 Integrated working – with the NHS and the Voluntary and Community Sector

8.3 Over the past decade, *integrated care* has become an integral part of health policy reform across Europe. In 2003, the World Health Organisation proposed that it was one of the key pathways to improve primary care (World Health Report: 2003). In 2004, the European Commission declared integrated care as vital for the sustainability of social protection systems in Europe[10].

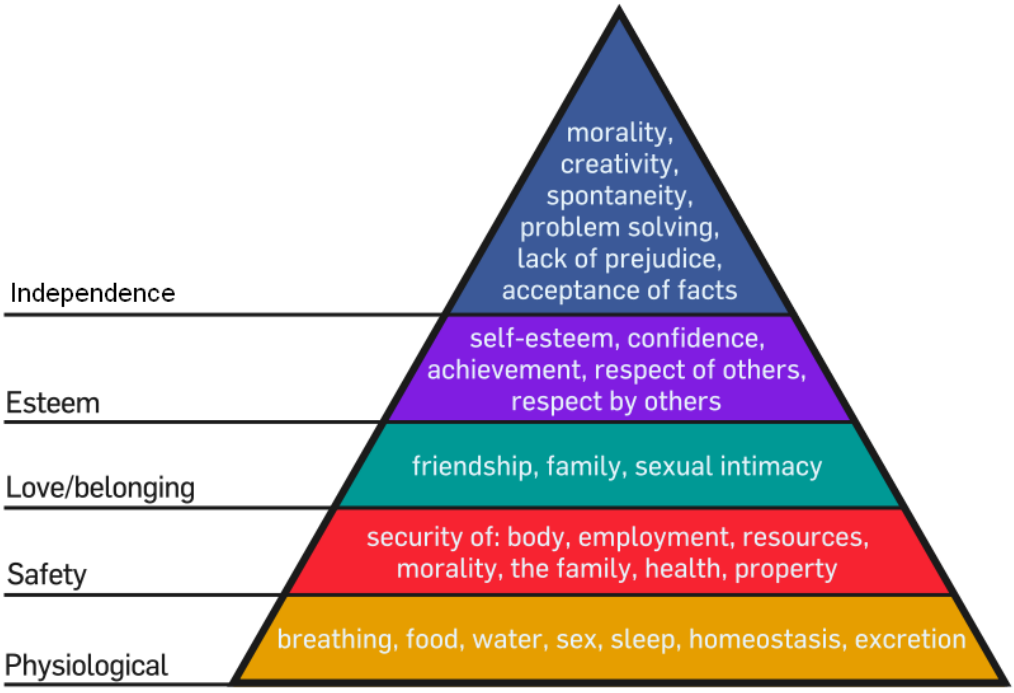
8.4 Unfortunately, there has also been a historic disconnect between policy intent and practical application with the NHS and Councils being reluctant to pool budgets for shared outcomes. The Group was pleased to find that the Council and CECPCT has somewhat bucked this trend - forging a strong mutual relationship with real tangible outcomes such as the formation of an integrated strategic commissioning unit. This will be further extended and strengthened by the Ageing Well Programme which is a large step forward in agreeing some shared outcomes with regard to health and social care.

8.5 After attending the LGA Smith Squared debate and listening to the various speakers, it was striking how much importance was placed upon facilitating practical integration. There was an optimism that the newly formed Health and Wellbeing Boards would help to achieve the Coalition Agreement pledge to 'break down barriers between health and social care funding to provide incentive for preventative action'. The group would implore that the Cheshire East Health and Wellbeing Board, when fully formed and operational, make integrated working a top priority. Additionally, the Group would also suggest that the Board monitor the transition between the outgoing CECPCT and the incoming Clinical Commissioning Group (CCG) so that the existing integrated practice is not lost.

8.6 The Group would assert however that this integration needs to go beyond the Council and the NHS so that the needs of older people are included in all

[10] http://www.ilcuk.org.uk/files/pdf_pdf_7.pdf

aspects of social policy. This idea has been influenced by Maslow's Hierarchy of Needs[11] which states that people have a range of needs (formed in a hierarchy) which need to be met in order to reach a stage of self-actualisation or independence (illustrated below). In the way that services are currently delivered for the majority of people through the Council and/or NHS it is only the more basic needs which are met, with some lower end and most higher end needs being neglected. The Group believes that this is an issue as it is only through older people feeling connected and part of society will they remain healthy and independent for longer.



8.7 There is a need therefore for the Council and its partners to think holistically about how to deliver social care for older people. It is no longer adequate for the care of the elderly to be the sole domain of the social worker and the care home as this only leads to a solution that is expensive, unwanted and occasionally unnecessary. The group therefore promotes the idea of a 'social care hub' which would be designed to include those partners best suited to deliver on all aspects of the hierarchy. This idea is expanded on page. 40.

8.8 Barriers to Independent Ageing:

8.9 Before thinking about any solutions to providing holistic and joined-up services for older people, it is a useful exercise to identify the existing barriers that are preventing some older people from retaining (or attaining) a level of self-actualisation and as a corollary; independence.

1) Poor, inappropriate or isolated housing/accommodation
2) Insufficient funding

[11] http://en.wikipedia.org/wiki/Maslow%27s_hierarchy_of_needs

3) Poor transport links and a lack of mobility
4) Poor health
5) Lack of support at home

8.10 Mitigation strategies

8.11 The Group has looked at these issues and has attempted to come up with a number of potential mitigation strategies.

8.12 Improving older people's housing options

8.13 The Wanless Review, 'Securing Good Care for Older People'[12], offered an analysis of people's preferences for housing and care as the table below shows. It illustrated that whilst there is a clear preference by older people to remain in their family home, many older people contemplate a move to alternative accommodation, although few people wish that to be residential care.

PEOPLE'S PREFERENCES SHOULD THEY NEED CARE:	**%**
Stay in my own home with care and support from friends and family	62
Stay in my own home but with care and support from trained care workers	56
Move to a smaller home of my own	35
Move to sheltered housing with a warden	27
Move to sheltered housing with a warden and other social care services such as hairdressing and organised social outings	25
Move in with my son or daughter	14
Move to a private residential home	11
Move to a local council residential home	7
Move to a residential home provided by a charitable organisation	3
None	1
Don't know	2

8.14 Such preferences are clearly not absolute but may be influenced by the choices that are on offer or indeed the perceptions people have as to what is available or is suitable. For example in the Netherlands, where there is a

[12] Wanless D (2006). Securing Good Care for Older People: Taking a long-term view. King's Fund.

wider choice of specialist accommodation for older people, the numbers wishing to move to alternative accommodation is greater than in the UK.

8.15 The Group suggest therefore that what is required is a strategic, cross agency approach to housing for older people that appropriately provides for a multitude of need. At the moment without better owner occupied homes in the community, there seems the stark choice between remaining and 'getting by' in an unsuitable family home or moving to some form of institutional care in unfamiliar surroundings. Unfortunately both of these options often end up putting extra cost onto the Council and produce a worse outcome for the resident. Unnecessarily entering residential care can firstly be costly to the individual and secondly reduce their quality of life. Also, if residents are staying in an inappropriate home, this greatly increases the chances that they will need to enter care earlier than would be potentially necessary.

8.16 To get over this issue there are three main options that the Council can pursue:

8.17 Improving people's existing homes

8.18 The Group was informed that the Council and its partners were already aware that housing was a key determinant of health and wellbeing. Recognising this, the Council has agreed to implement a new private sector housing financial assistance policy, which sets out what sort of help the Council will offer to older people and people with disabilities to repair and adapt their homes.

8.19 More than £1.4m has been approved to implement the policy. This will be used to:

- Remove the most severe health and safety risks for vulnerable homeowners;
- Tackle fuel poverty;
- Enable people with disabilities to live independently; and
- Bring empty homes back into economic use and increase the supply of affordable housing.

8.20 The policy will help to reduce risk of home accidents, improve health and wellbeing, reduce fear of crime and increase opportunities to access suitable housing.

8.21 The Group was informed that the Council currently only provides a Disabled Facilities Grant (DFG) when an individual has a critical or substantial need – in line with the Council's FACS criteria. In taking a preventative approach, it is suggested that it would be helpful to provide adaptations at an earlier stage (e.g. through discretionary loan funding) as this would reduce the demand for the mandatory (and more costly) DFG grant. Such a use of earlier adaptations could also possibly reduce early admission into residential care, prevent

injuries and hospitalisation and promote independence. Indeed, such a loan could enable people to plan for their future rather than reacting to a crisis.

8.22 In line with a preventative approach, the Group would also suggest that the Council explore putting more money into the housing financial assistance policy (beyond the £1.4 million already identified) and the discretionary loan funding budgets. This could be funded through capital borrowing as it is felt that the savings created in the revenue budget (by preventing people entering care) would more than offset the cost of borrowing.

8.23 In addition to people's homes, the Group would also like to draw attention to the need to improve neighbourhoods. Indeed, if the Council cannot deliver the objective of maintaining more people in the community without suitable and appropriate housing being in place then equally housing cannot deliver that outcome without people feeling comfortable and safe within their communities and neighbourhoods.

8.24 Good neighbourhood design for older people can mean a variety of things, such as:

- Are health and care services grouped in the areas of highest density?
- Are there nearby shops and banks and are shops and banks accessible to older people, particularly those with mobility scooters?
- Are neighbourhoods considered safe, eg, what are the reaction times on street lighting failure, is access to property safe and secure?
- Are transport systems accessible?
- Is there a structured plan for the installation of drop kerbs?
- Is there easy access to a range of social activities and facilities?

8.25 Improving integration with planning

8.26 Ensuring that neighbourhoods are suitable for older people is not just the responsibility of adult social care. The use of the planning system is a key component in ensuring the quality and supply of an effective older person's housing market, and extra care housing in particular. Anecdotally, social care officers have informed the Group that a lack of links with and understanding of, planning in the past has meant that older people's needs have not been considered or prioritised when planning applications or new housing developments are considered. Indeed, the Group would suggest that the following steps are considered to support the delivery of the agreed local vision for housing suitable for older people[13]:

- Ensuring robust and up-to-date evidence reflecting older people's needs is available to support planning decisions.

[13] *Royal Town Planning Institute (2006). Good Practice Note 8: Extra Care Housing: Development, planning, control and management.*

- Responding to consultation planning documents to ensure older people's needs and preferences are reflected within them, and that they will support the delivery of local policy.
- Regularly consulting with and updating planners about local policy direction. There are three areas in particular where this is likely to prove helpful:
  - Responses to planning applications for new care homes and how to ensure they fit with the local policy direction as far as possible.
  - Supporting the development of new extra care housing schemes.
  - Supporting the development of other forms of housing for older people as part of local regeneration mixed use developments.
- Ensuring there is a clear strategic approach setting out local preferences in terms of whether a predominantly housing model or residential care model is preferred.
- Developing a clear approach to Section 106 (or similar) applications in support of older people's housing.
- Development of pre-planning guidance for independent and voluntary sector developers which outlines the local authority's vision for extra care housing and older people's housing and any minimum requirements would assist in ensuring that any potential developers had an understanding of expectations prior to application. This may form part of the Market Position Statement, Strategic Housing Market Assessment, or an existing Local Development Framework.

8.27Increasing Sheltered Accommodation placements

8.28 Following on from the latter point, the Group was made aware that Extra Care Housing had emerged as a useful intermediary (or alternative) option for older people who may have previously thought their only options were either staying in their own homes or moving into care.

8.29 Extra care housing takes a number of different formats and styles, but primarily it is housing which has been designed, built or adapted to facilitate the care and support needs that its owners/tenants may have now or in the future, with access to care and support twenty four hours a day either on site or by call.

8.30 To qualify as extra care housing, it was explained that a development needed to provide facilities such as Restaurants, Libraries/IT Rooms, Community Halls, Fitness Suites, Craft Rooms, Lounges, Shops and Hairdressers to their residents and the wider community. Extra Care Housing usually constitutes one or two bedroom flats which can be rented (from £72.54 per week), bought through shared ownership (from £61,500) or bought outright (from £125,000). Residents then often pay a service charge on top of this.

8.31 The Council currently has six schemes situated in the Borough of which a number were partly been funded by the first round of Private Finance Initiative (PFI) credits from the central government. A company called 'Avantage' has been appointed to design, build and operate the PFI schemes for Extra Care Housing and it was noted that these were located in the following areas:

- Crewe, Beechmere (Avantage):
  132 apartments - opened in August '09
- Handforth, Oakmere (Avantage):
  53 apartments -opened in January 2009
- Middlewich, Willowmere (Avantage):
  71 apartments - opened in April 2009

8.32 Extra Care Housing is also provided in the following sites through Housing Associations:

- Congleton Heath View (Plus Dane):
  45 apartments - opened in January 2010
- Crewe, Pickmere Court (Wulvern):
  65 apartments – opened in May 2011
- Nantwich, Mill House (Wulvern):
  43 apartments - opened in September 2008

8.33 The case for developing additional Extra Care Housing in Cheshire East appears strong. There is a wide range of national evidence which shows that they improve the health and wellbeing of residents whilst reducing costs. An evaluation of an extra care housing scheme in Bradford sought to understand both the costs and the outcomes delivered by the scheme[14]. It found that the better health enjoyed by those living in the scheme meant that health care costs were lower (more than a 50% reduction), mainly through a reduction in the intensity of nurse consultations and hospital visits.

8.34 It concluded that it was primarily the higher levels of formal support which had resulted in improved outcomes for residents and carers; unmet needs associated with people's previous community care packages seemed to have been met by care services and support provided at the extra care scheme.

8.35 This was a finding that was reflected in the Group's own findings following a visit to the Beechmere scheme in Crewe. In a discussion with the residents, it was clear that there was a general consensus that they were happy with their accommodation and that they enjoyed the community feel and added security that the development provided. Of particular note was that a number of residents with relatively complex dementia needs were resident

[14] Joseph Rowntree Foundation (2008). Costs and outcomes of an extra care housing scheme in Bradford.

within the scheme and that since they had resided at Beechmere their condition had improved. It was also reported that Beechmere had very few referrals onto nursing homes as it tended to be able to cope with all needs until a resident passed away.

8.36 Having said this, it was also clear to the Group that Extra Care Housing is not a panacea. Following a conversation with Mr. Adrian Lindop, Chairman of the Crewe and Nantwich Seniors Voice Group, it was noted that there were a number of issues that the Council needed to be aware of with regards to Extra Care Housing. He described how Extra Care Housing was not for everyone as it could sometimes prove an isolating experience, particularly in large schemes (100+ units) that were a way out from the town centre. This was less of a problem in smaller 30-40 unit schemes. He also noted that it could be expensive, especially when the service charge was factored in.

8.37 There were also some concerns expressed by the Group with regards to the financial model of Extra Care Housing. It was explained that there is potential for the Council to save approximately £50 per week on each residents care cost if the right mix (high, medium & low need) of residents are in place. In the current schemes, there is a high level of low need residents which is causing the saving target to be unmet.

8.38 In summary, whilst the Group agrees with the rationale behind Extra Care Housing, namely keeping older people engaged and active in a safe environment, there is a feeling that the principle behind them is somewhat incongruous with the proposed direction of travel outlined in the rest of this report. This is based on the evidence collected by the Group which suggests that Extra Care Housing Schemes tend to be built in isolated parts of towns, thereby creating a distinct community of older people disconnected from mainstream society. Indeed, the claim that other parts of the community would access the facilities in the schemes was felt optimistic and there was no evidence to illustrate that this was occurring in the scheme visited by the Group.

8.39 Whilst not completely disregarding the principle of Extra Care Housing, the Group would argue that for a scheme to be successful it needs to be fully embedded in the wider community (i.e. near shops and on a bus route), affordable (for the resident and the Council) and small enough to feel personal. It is felt that this could be achieved by using a more traditional model of sheltered accommodation with better links made to existing community facilities. These could also be linked to the social care hubs outlined on p.40.

8.40 Improving older people's transport options

8.41 Throughout the review it is recognised that a feeling of independence is vital for older people if they wish to achieve the higher echelons of Maslow's Hierarchy of Need. One of the key elements of maintaining independence is

the ability to access transport and a lack of good transport can be a significant barrier to social inclusion and independence – two of the very things that help to keep people happy in their own homes.

8.42 With this in mind, the Group was concerned to hear about changes to community transport following a conversation with representatives from Crewe, Congleton and Nantwich Dial-a-ride (ran by the Charity East Cheshire Community Transport [ECCT]). The Group was informed that ECCT had lost a total of £120,000 in annual funding - £45,000 of which had been lost as a result of a reduced grant from the Council and £74,000 which had been lost due to the removal of the ability of the service to operate under the concessionary travel scheme. This was a scheme that allowed elderly people to use their bus passes to travel free after 9.30am. Dial-a-ride would then receive a 62% reimbursement of the fare from the Council.

8.43 This loss of funding meant that ECCT had to increase their charges to retain the service and the Group was informed that this had resulted in a 20% drop in bookings from the elderly. When it was queried why ECCT had lost the ability to claim back costs under the concessionary travel scheme, it was explained that to qualify the service would have to apply to the Traffic Commissioner to register as a bus service. The issue for ECCT is that to register as a bus service, there would be the need for an expensive operator's license and the vast majority of their drivers would need to be trained to obtain a Passenger Carrying Vehicle (PCV) license. The Group was subsequently informed that ECCT had ceased to trade on 16 May 2012 due to financial pressures.

8.44 The Group was also informed that the situation in Crewe, Nantwich and Congleton was in contrast to the arrangement in the North of the Borough in which the newly formed Macclesfield Area Flexible Transport Service could access the concessionary travel scheme due to having an operator's license.

8.45 In trying to gain an understanding of how many people the closure of ECCT would affect, the Group was informed that 900 residents had used Dial-a-ride in 2011 and that they had made 45,000 journeys in total (one journey per fortnight on average for each service user). To outline the importance of this service, it was noted that if these 900 people were in Council funded residential care they would cost £18 million per annum. Therefore, even if only a small percentage of the 900 fell into residential care as a result of losing their independence, it could potentially be very costly to the Council.

8.46 In the process of conducting this review, The Group was informed that a replacement service has been found for the South of the Borough and therefore the impact on the residents who used the former Dial-a-ride service has been minimised. Whilst this is pleasing to note, the Group does have a number of concerns about how the transition was managed both in the North and the South of the Borough. For example in the North, there was uncertainty about the future of the dial-a-ride and shopmobility service with

no clear succession or exit strategy in place right until the contract end date. This unsettled staff and residents alike and could have been avoided with better forward planning. In the South of the Borough, it was well documented in the media that Dial-a-ride ceased to trade, partly due to a change in the relationship with the Council. With no replacement service in place for two weeks this affected a large number of residents and reflected badly on the Council.

8.47 The Group feel that both of these cases could have been avoided if the Council was better 'joined-up' in its thinking. The point here is that one department made a saving which had a knock on effect onto another department. To reduce the chances of this happening, or at least to create awareness that it might happen, the Group suggests that any budgetary proposal should include an impact assessment on other areas/functions of the Council.

8.48 As a final point, the Group would also wish the Council to note the 3,300 residents aged 65 and over who have a higher mobility allowance. It is suggested that the Council attempt to target these residents so that they maximise their own income when using transport whilst also reducing the cost for the Council.

Table 6 - Higher Mobility Allowance figures for Cheshire East

Age	Total	Higher Rate	Proportion
total (all ages)	15,070	8,590	57.0%
Aged 60-64	1,970	1,460	74.1%
Aged 65 and over	4,150	3,300	79.5%

8.49 Caring for those who care

8.50 This review has, on the whole been about mitigating demand on Council funded residential care by finding strategies and methods to keep people independent and healthy for longer. The role that home carers play in this is highly significant and they very much are the 'first line of defence in prevention'[15]. Indeed, the paper 'Valuing Carers 2011' by Carers UK suggests that there are 'over six million carers [taken from 2001 UK census], family, friends and neighbours who provide unpaid care to someone who is ill, frail or disabled. The care they provide to help sustain people in their own homes and in their own communities is vital'. Without this care, they argue, 'society would collapse'.

8.51 This could be considered hyperbole but the same study quantified the value of carers and found that the economic value of the contribution made by

[15] Department of Health (2010), 'A Vision for Adult Social Care: Capable Communities & Active Citizens'. London: Centre of Information.

carers in the UK is a remarkable £119 billion per year. To put this into context, the 2009-10 budget for the NHS was £98.8 billion.

8.52 Considering this, the Group was concerned by evidence which suggests that a significant number of hospital and care admissions are due to problems associated with the carer rather than the person admitted. One study found that problems associated with the carer contributed to readmission in 62% of cases. Carers of people readmitted were more likely than other carers to[16]:

- be experiencing ill-health, fatigue and interrupted sleep;
- be conducting at least one intimate task;
- and generally feel frustrated.

8.53 A whole systems study tracking a sample of people over 75 years old who had entered the health and social care system, found that 20% of those needing care were admitted to hospital because of the breakdown of a single carer on whom the person was mainly dependent.[17] These studies substantiate the Group's belief that supporting carers is vital to reducing the burden on social care services and therefore retaining the independence of the individual.

8.54 The Group was pleased to note that the Council has already recognised this issue and as a result has implemented a number of initiatives for supporting carers. At the forefront of these is the recently established Carers Strategy which has used the following key points from a report produced by the Princess Royal Trust for Carers and ADASS called 'Supporting Carers – Early Intervention and Better Outcomes' as a framework:

- Early intervention is integral to personalisation.
- Applying early intervention thinking to the support of carers can lead to better value for money and better outcomes.
- There is an evidence base to support the claim that carer support can create savings for adult services.
- Considering carer support in the context of major care pathways such as hospital discharge, falls, dementia and stroke could generate systems-wide efficiencies.
- Systematic information collection from service users and carers would improve the evidence base and improve the investment of limited resources in both health and social care.

8.55 Having said this, the Group also became aware of a number of areas which could be further improved. Firstly the Group feel that if the Council is to make the most of the strengths that carers can provide, the steering group which co-ordinate the Council's policies on carers will need to be

[16] Williams, E, Fitton, F (1991), 'Survey of carers of elderly patients discharged from hospital'. British Journal of General Practice, 41, 105-108.

[17] Castleton, B (1998), Developing a whole system approach to the analysis and improvement of health and social care for older people and their carers: A pilot study in West Byfleet, Surrey. Unpublished. Referenced by Banks, P (1998) 'Carers: making the connections'. Managing Community Care, vol 6, issue 6.

strengthened and further resourced. It is felt that the current situation of 1.3FTE staff is inadequate to deal with the both the current and future demands of the service. To highlight this issue, it is important to note that the estimated number of carers in Cheshire East is 39,829 (from 'Valuing Carers 2011' Carers UK) with the number of people known to the Council as Carers on the PARIS social care system is 4,474. The Valuing Carers report estimated that these figures had increased by 36% since 2007.

8.56 If this team was extended to 3 FTE, it is expected that this would cost £61,900pa for the extra 62.5 hours per week (including on costs). It is suggested that this is explored by the service.

8.57 A result of this lack of resource has led to what has been described as the 'hit and miss' nature of carer assessments. This is partly caused by the slowing of carer assessments due to the high caseloads of the SMART teams. The Group was informed that Trafford Council has commissioned out its carer assessment process to a degree of success and it is suggested therefore that the Council explore this option by funding a pilot study. It is also suggested that the Council look at trialling the standardisation of the collation of carer information across all Voluntary, Community and faith sector partners who support carers. This would enable the Council to review the quality and consistency of the information and the escalation of carers needs.

8.58 As previously stated one of the main reasons why people enter care prematurely is due to the breakdown of their carer on which they are dependent. It is obviously in the individual's and the Council's interest therefore to support carers in order to delay this process or prevent it from happening at all.

8.59 The budget for the Adult Services carers' team is a complex picture. The majority of money comes from a Carers Grant, distributed to the Council from Central Government. Whilst this is no longer ring fenced, in 2010 it was agreed that all Department of Health revenue grants for adult social care, including the Carers Grant, would continue to rise in line with inflation for the following four years (to the financial year 2014/15) and be paid through the Local Government Revenue Support Grant. Based on this, the figure that Cheshire East Council received for the financial year 2010/11 was £1,436,322. 20% of this historically always went to Children's Services (£287,264), which would leave £1,149,058 in the Adult Services budget.

8.60 The budget for the Adult Services Strategic commissioning carer's team for 2011/12 was not given any uplift from 2010/11, so the amount coming into Adult Services for carers remained static at £1,149,058. Any inflation allocated corporately was earmarked in full by Adults Services to contribute towards known departmental financial pressures. Of that, £781,416 was allocated directly to the carer's budget. This covered both the staffing of the adult services carers' team and the commissioning of services from third sector organisations. These services are currently a mixture of information

and advice, support groups, carer breaks, training and a carers fund which can be applied to for small amounts of money to sustain carers in their role (detailed below).

8.61 The draft carer's budget for 2012/13 is currently £639,363 which has been put into the Needs Led budget build. There will be a major recommissioning exercise in 2012/13 taking into account the overall priorities for service provision for carers. The Council will potentially be retendering some contracts and looking for provision in some new areas. These new contracts should be in place of the beginning of the financial year 2013/14.

Organisation	Service provided
Alzheimer's Society	• Dementia Outreach Service • Early Onset Dementia Service To provide carer breaks and support to carers and family members of people with dementia type disorders. The service offers peer support groups, lunch and café groups, training and awareness for carers supporting a family member with dementia and a counselling service. The Alzheimer's Society provides specialist support to carers and people with dementia type disorders.
The Neuromuscular Centre	• Carers Project The Neuromuscular Centre supports carers of people with neuromuscular conditions. Support is in the form of advice, guidance, and carer breaks. The Neuromuscular Centre is both a local and national service offering specialist advice and support to carers of people with neuromuscular conditions.
Crossroads Care Cheshire East	• Take-a-Break and CAMEO Carer Support Groups • Social Skills Group for Adults with Aspergers • Hidden Carers • Carers Emergency Response Service (CERS) Crossroads Care Cheshire East provides practical support for carers and those they care for. The services funded are listed above. The services provide carer breaks to unsupported "Hidden" carers and provide an emergency support service for carers across Cheshire East. This provides a short period of cover for the cared for to ensure that they do not have to go into respite while the situation is stabilised.

Making Space	• Adult Carer Breaks • Older People Carer Breaks • Carers Development Service Making Space works with people with mental health issues. They carry out Carer Assessments on behalf of the Local Authority. They provide carer breaks and carer support groups and offer a high level of expertise to carers of people with mental illness. They also support carers who would like to access employment, education, and training.
Cheshire Carers Centre	• Core Information and advice • Carers Fund • Training and personal development • Pamper sessions • Caring at home courses The Princess Royal Trust Cheshire Carers Centre provides a range of information, advice, advocacy and support services for carers. Services include a carers' helpline and at-home service including advice on finance and benefits, training, drop-ins and carer support groups, carer breaks, regular newsletters, a Carers' Fund which allows carers a one-off payment for specific services or essential items.
St Lukes Hospice	St Luke's Hospice provides specialist support groups to carers supporting people with long term or terminal conditions

8.62 Money which was previously held within the carer's budget is now administered by Care4CE, with £367,642 being used towards various services such as Warwick Mews, Family Based Care and Mental Health Outreach. Additionally, outside the carer's budget, the council also commission £92,000 of carer breaks from Crossroads care and Making Space provides carer assessments for carers of people with mental health conditions.

8.63 Considering the importance of carers in preventative work, the Group feels that there is a strong case for taking an 'invest to save' approach to carer funding. This assertion is mainly evidenced by a report called 'Supporting Carers - The Case for Change', jointly produced by The Princess Royal Trust for Carers and Crossroads Care.

8.64 Analysis of this document and its implications for Cheshire East was subsequently undertaken by Andrew Brown, a Senior Information Officer in Cheshire East Council. The headline findings from this analysis are outlined below. The full analysis can be found in Appendix 1 of this report

8.65 *Up-to-date cost savings*

8.66 Since the document was produced, the NHS Information Centre has published the 2010/11 figures. It is possible to update the figures in the

document with more recent information than had been available at the time it was written.

8.67 Updating the Cheshire East figures using 2010-11 PSS EX1[18] information gives the following. The table below shows the results of this, using the original assumptions that the overall number of weeks of residential care in Cheshire East could be reduced by 25% with a home care package 25% above the average amount. An indicative amount of £50 per carer per week was also included in this calculation.

Residential weeks decreased by	Increased expenditure on carers	Increased expenditure on Care at Home	Decreased expenditure on residential care	Overall savings
21,841	£1,092,038	£7,726,341	£11,469,250.00	£2,650,871

8.68 *Alternative Scenarios*

8.69 Alternative scenarios were modelled to find out what the variance in cost savings would be. In the original report, a reduction on 25% of residential usage was assumed with a package 25% higher than average. The subsequent analysis looked at lower reductions in usage, with a higher average package of care as a more likely situation. This produces a predictably large variance in potential savings. With a reduction of just 10% of residential usage and an increase in the home care package to 50% above the average, the estimated saving in a year is £442,241. This is in contrast to the £2,650,871 quoted above. This shows that the proportion of weeks that can be converted from residential to home care and the increase in home care costs these would bring are crucial in calculating the possible savings for Cheshire East.

8.70 *Issue of Year 1*

8.71 In 2010/2011, Cheshire East admitted 560 clients to permanent residential and nursing establishments over the course of the year. If, in the future, we continue to place at that same rate (around 11 clients every week), we cannot converting the full number of residential weeks to home care weeks from week 1. In Year 1 there would be a gradual implementation of the process as small numbers of people who would have otherwise gone in to residential care are then supported at home. To make substantial savings in a shorter time scale, residents already in care homes would need to be identified who could be supported at home after all.

8.72 *Impact on the market*

8.73 The private and voluntary sectors have enjoyed growth over recent years through the shift away from internally-provided residential care and the expansion in the social care market in general. This would be a significant reversal of their business and would need to be carefully discussed with

[18] Personal Social Services Expenditure Collection

Strategic Commissioning due to the impact it could have. There would also be an increase in the provision of domiciliary care. Important factors to consider would be around the availability of the home care workforce and potential bottlenecks around popular times of delivery of care.

8.74 *Carers*

8.75 In the Princess Royal Trust report there is an indicative provision of £50 per carer of a service user who was kept out of residential care. If this was taken as an amount to be paid directly to the carers concerned it would mean that we would need to know each client kept out of residential care who had a carer who we would be offering the enhanced carer payment. This would then raise the question of how we identify the carers in question. A further consideration would be whether some existing carers qualify or whether this is only applicable to new assessments.

8.76 There may be carers providing high levels of care for persons who **do not** satisfy either the criteria for residential care admission or the criteria by which they would have been admitted had it not been for this scheme. The support given by these carers is likely to be no less in terms of quality, quantity or importance to the service user's wellbeing than those we have identified for this enhanced carer payment and there may be issues over fairness and differentials in financial support.

8.77 Even if the financial resource for carers is taken as an indicative amount to be used to commission services which provide a higher level of support, there are considerations. It is necessary to consider what the impact would be on respite provision for an increased group of carers and cared for persons. The proposal also presumes a large increase in training for carers. The types of training, capacity among organisations to deliver it, and increased respite for the cared for would all need to be considered.

8.78 Having taken into account all of these factors and caveats, the Group still believes that the case is strong for investing in carers. A further question is where best to target such investment. The Survey of Carers in Households 2009/10 (the Health and Social Care Information Centre, 2010) found that nationally 62% of all carers felt that their general health was good, 8% felt it was bad, and 30% described it as 'fair'. However, for carers who cared for someone in the same household as themselves for over 20 hours a week, only 52% felt that their health was good, and 8% described it as bad. This suggests that a graduated approach to carer support is necessary, where a low level of support – for example information and signposting – is available to the majority of carers and a higher level of support – for example carer breaks – is available to those with a more demanding caring role.

8.79 Regarding carer breaks, the Group were informed of a personal budget pilot for carers which had been trialled in Crewe through one off PCT funding. This supported carers in taking a break from their caring role by providing them with a personal budget to spend on things they enjoy such as hobbies or a

weekend away. The Group suggests that the Council should explore extending this pilot across the Borough.

8.80 Having said this, there is also evidence that are people with personal budgets who are unnecessarily using third sector partner services for respite – causing preventable capacity issues. It is suggested that the Council work with these third sector organisations to improve their assessment processes in order to stop this from happening.

8.81 Whilst the Group would call for more funding into Carers and Carer Support, the complexity of the issues involved is recognised. It is suggested therefore that the Adult Social Care Scrutiny Committee receive a series of reports detailing the various areas of pressure in terms of carers. Recommendations to Cabinet could then be made following the consideration of the reports.

8.82 Delivering a co-ordinated and holistic service for Older People

8.83 This report has so far outlined the need for change in how social care for older people is delivered whilst briefly making the case for a co-ordinated approach that makes all aspects of social policy work for older people. This is an attempt to move away from the narrow view that social care for older people is the sole domain of social and care workers, hidden away from the rest of the community in residential and nursing homes.

8.84 In the previous section, the report has described how various changes could be made to specific areas of social policy, such as housing and transport. Whilst the Group feels that these changes are necessary, it would assert that it is making a change to how services are integrated and subsequently delivered that is the most important and radical step.

8.85 It has been noted that the Council and the NHS have already made some important strides in achieving integrated working in Cheshire East. The Group would assert however, that this process and partnership needs to be widened and extended to include other areas of the Council and to treat the Voluntary and Community Sector (VCS) as equal partners.

8.86 This is following a belief that the UK (and therefore Cheshire East) should start to look towards a Nordic model of adult social care, and particularly follow the example of Denmark.

8.87 Danish Social Care[19]

8.88 Denmark undertook a deliberate shift in the 1980s. It stopped building nursing homes, and began providing both a housing function and a service function to its ageing population.

8.89 The year 1987 saw a number of legislative acts on housing, urban renewal, services, and education of health workers. The Housing Act for the Elderly set standards for contained dwellings. Twenty per cent of all renovated dwellings must be accessible for older people (adapted bathrooms, tele-alarm systems, etc.), and housing adaptations are arranged by local authorities and financed with public loans. Fully 71 per cent of those 85+ in Denmark still live in their own homes.

8.90 Local community service centres, almost all of which are 24-hour, provide a variety of health care and home-help services, including assistance with activities of daily living, housework and shopping. Mobile services include meals on wheels, gardening, transport assistance, and snow-ploughing. Nursing and care services also come to the home. Home helpers and nurses

[19] All Denmark data is summarised from two sources: 'Home- and Community-Based Long-Term Care: Lessons from Denmark', M. Stuart and M. Weinrich, *The Gerontologist*, 41(4), 2001: 474–80; and 'Housing and Service for the Elderly in Denmark', B. Lindstrom, *Ageing International,* 23, 1997: 115–32

are based in and dispatched from the local community centre. The local centre is itself a lively place, with a variety of social and recreational activities available. The Home Help Standard in Denmark is one full-time employee for every ten persons aged 75-plus.

8.91 The municipality of Skaevinge provides a great example of a radical approach to delivering elderly services. Skaevinge eliminated its nursing home in 1984, turning the facility into a senior centre, day care, rehabilitation, 24-hour home care, and assisted-living centre in one. An evaluation of the Skaevinge project found high levels of satisfaction among residents and staff, improvements in both actual and self-reported health status, and reductions in hospitalisations. The proportion of individuals in Skaevinge rating their health as better than average (when compared to their peers) rose from 29 per cent in 1985 (at the inception of the project) to 41 per cent in 1997[20]

8.92 Lesson learning and policy exchange from other cultures and contexts is inherently fraught with difficulties as what works in one place will not necessarily work in another. Having said this, the Group feels that the general principle found in Denmark is sound and that Cheshire East should take a similarly conscious decision to incrementally disinvest in care homes and instead shift funding into preventative work delivered in the community (and where appropriate by the community).

8.93 This is not to say that there wouldn't be difficulties in achieving this and the Group have identified the following issues as potential barriers to such a change that would need to be removed or rectified.

- Not engaging in sufficient dialogue with partners from health and the VCS so that a long term and sustainable strategic delivery plan could be agreed.
- Once a long term and sustainable strategic plan had been agreed, not ensuring that long term funding is in place.
- Clinical Commissioning Groups not being sufficiently 'community focused' or aware of the service provision on offer within the VCS.

8.94 To demonstrate that these barriers would not be insurmountable there is already examples both from around the UK and in Cheshire East which show that a model based on the Danish principle is feasible.

1) Cockermouth Centre for the Third Age (C3A)
2) Suffolk Circle
3) Macclesfield Health and Wellbeing Centre
4) Care4Care

[20] Integrated Health Care for Older People in Denmark: Evaluation of the Skaevinge Project 'Ten Years On', L. Wagner (available at: www.oita-nhs.ac.jp/journal/PDF/2_2/2_2_3.pdf)

Cockermouth Centre for the Third Age (C3A)

The Centre for Third Age, although still developing, has been an interesting experience in testing out how the Third sector can contribute to the future health economy and improve the lives of all older people.

Development of the Centre

Prior to the floods, discussions regarding a new health centre in Cockermouth were already in progress and in June 2010 plans for a new health centre were well under way. A consultant was appointed to consider alternatives for the old hospital premises. One idea was a centre to support the Third Sector. At the invitation of the Director of Public Health, Prof. John McKnight fired people's imagination with the concept of Asset Based Community Development (ABCD). The concept struck a chord with local health professionals who had experienced first-hand the response of the Third Sector to the 2010 floods. A meeting of interested parties was convened and the idea of a Centre for the Third Age began to emerge. A Management Consultant/Project Manager was employed by the NHS to run the project.

How it works

The centre works through two means:

1) *Physical centre*
   The centre currently consists of two rooms:
   a. Room 1 is the hub of the centre; it houses the information point, is staffed and is where the referral and signposting processes take place.
   b. Room 2 is a bookable room available to third sector organisations.

   The physical location of the centre, next to GP surgeries, appears to have been beneficial in establishing the necessary links and relationships with health professionals.

2) *Virtual Centre*
   The centre will also have an online presence which will be a 'virtual centre' to match the 'physical centre'. This will include searchable and relevant sources of advice on local services for local older people which encourages people to seek and provide help on a mutual basis; achieved largely by research (local and hands-on), also through improved design and presentation.

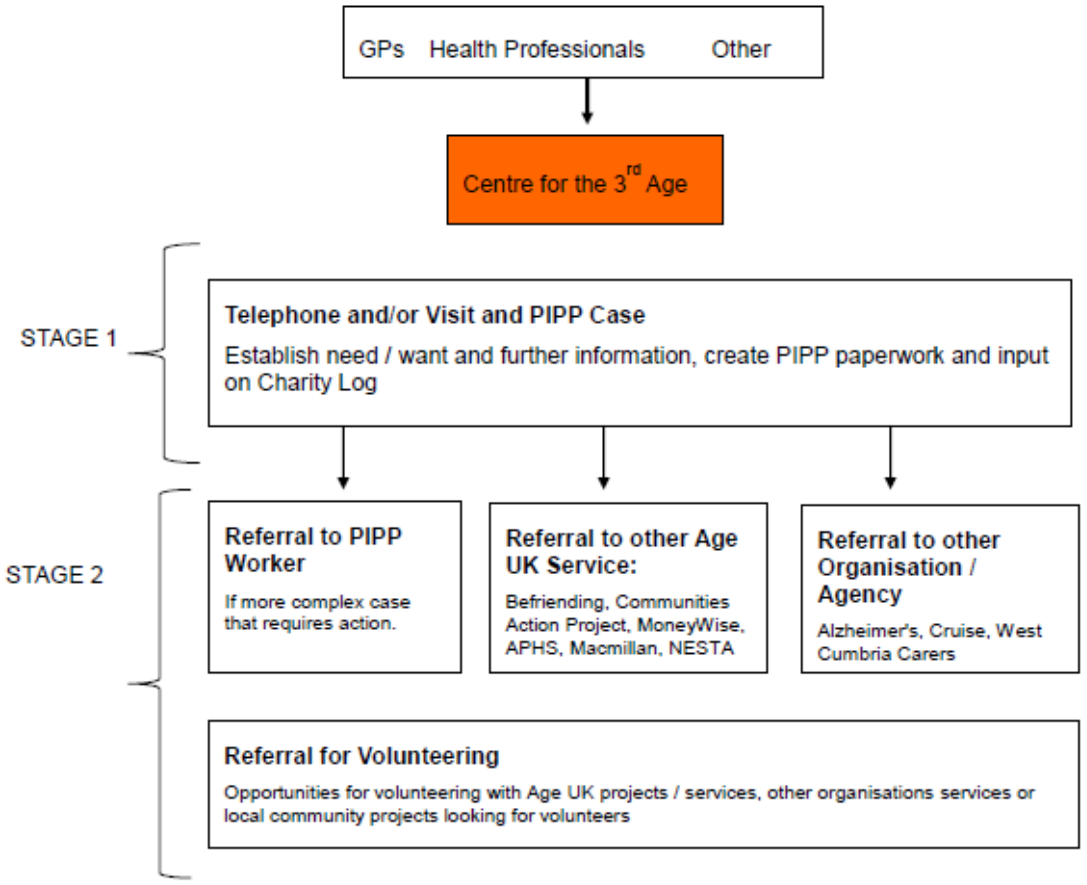
Cockermouth Centre for the Third Age (C3A)

GP Referral and Engagement with Health

A key focus of the project has been to develop a streamlined referral system that would encourage referrals and ensure GPs had faith in the system and received good quality feedback on how it was working for their patients.

The current system being piloted goes back to basics with a single form (shown below) that is quick and easy to complete. GPs can pass on the details of the patient and record what they think the C3A can help with. The form is now on every GP's desk on the site. This is a low cost system using a form that can be adapted or amended to accommodate changes in services available, or changes in what patients need. The diagram below shows how the referral system currently works.

Diagram 2 C3A referral process



Cockermouth Centre for the Third Age (C3A)

Referral to the Centre for Third Age

Name: .....

Address: .....

.....

Telephone: .....

D.O.B .....

Tick

Has consented to referral [ ]

Name of Referrer: ..... Position:.....

Date: .....

	Please tick
General Advice & Information	
Help at Home	
Handyperson Scheme	
Nail Cutting	
Benefits Advice	
Equipment for Daily Living	
Low-level Nutrition Needs	
Social Diary	
Supported access to internet	
Volunteering	

	Please tick
Support for Activities at Home	
Support for 'Befriending'	
Support for Dementia	
Support for Falls Prevention	
Support for Stroke	
Support for Bereavement	
Support for Hospital Discharge	
Support for Prevention of Admission	
Support for Carers	
Support for Activities & Exercise	

To the PATIENT/CLIENT OR CARER:

- **This form can be handed in at Reception**

  OR

- **You can take it directly to the Centre for Third Age**
  Cockermouth Hospital, Isel Road, Cockermouth CA13 9HT
- **Telephone: 01900 828393**
- **Email: cockermouth@ageukwestcumbria.org.uk**

Suffolk Circle

On 25 May 2010 the Cabinet of Suffolk County Council endorsed their support for the development of a Suffolk Circle Community Interest Company. Suffolk has supported an organisation called "Participle" to develop the Suffolk Circle model based on similar work in the London Borough of Southwark.

In summary, Suffolk Circle is a membership organisation open to anyone over the age of 50 years. An annual membership fee of £30 (or £2.50 a month) enables members to have access to social activities, a phone number to call for practical advice, a personalised membership pack and monthly letter. Once a member, virtual tokens can be purchased at a cost of £6 (or £30 for 6) which can be used for a range of social events, visits and practical help provided through a network of helpers. A £6 token can be used for a ½ hour helper visit. Some examples of the types of things helpers might give a hand with include gardening, DIY, technology and transport. The Suffolk Circle covers the helpers' expenses and, by becoming a member as well as a helper, tokens can be earned through helping which can then be used to take part in events or in exchange for practical help.

Based on research undertaken locally, Participle projected that the model would be self sustainable by the end of its third year, on the basis of a minimum target of 3,500 Circle members. A County Council investment of £680,000, over three financial years, was agreed by Cabinet on 25 May 2010 to support the development of the model.

The Suffolk Circle was officially launched in Suffolk on 14 February 2011. The Circle is now into its second year of operation and has been developed in the West of the County in Year 1. It is planned to roll out across the whole of Suffolk by the end of Year 3.

Age UK Cheshire East Health and Wellbeing Centre – Macclesfield

Age UK Cheshire East has developed a community hub model at its Health and Wellbeing Centre in Macclesfield. The centre provides healthy lifestyles activities including Zumba, Tai Chi, arts and crafts, and houses the Men in Sheds project. The Centre also has a counselling service and an information and advice outreach surgery. Services such as Help at Home go out into people's homes. The organisation is planning to replicate this model in other towns in Cheshire East.

Care4Care

Care4Care is the brainchild of Professor Heinz Wolff. He has a long and distinguished career and is the Emeritus Professor of Bioengineering at Brunel University and the former director of the Bio-engineering division of the Clinical Research Centre of the Medical Research Council. Along with the Young Foundation and Age UK, Professor Wolff launched a Care4Care pilot in the Isle of Wight in March 2012.

How it works:

As a Care4Care member, all the time an individual spends supporting or caring for an older person is "banked" as Care Credits, providing individuals with a way to plan for their own future. Time is measured in quarter, half and whole hours, so that if an individual pops in to check on someone for just 15 minutes a day, they would still be accruing valuable care credits.

The Care Credits a person banks can be used in two main ways:

> The main aim of the scheme is to help people prepare for their own older age. When an individual starts to need support, they can spend their Care Credits that they have built up: they don't have to have the same type of support they gave to someone else. For example, someone who accrued 300 hours' worth of Care Credits by driving their elderly neighbours to the doctor and doing supermarket shopping could choose to 'spend' their credits on help with light cleaning and regular companionship.
>
> A second way you can spend your Care Credits is to use them to support a loved one immediately. This can be particularly appealing for people who live some way away from ageing family members or friends. For example, if you are living in Suffolk but have a parent in Newcastle, you can help them at a distance through Care4Care membership. You help a local older person, banking your Care Credits. You then spend them on your mother in Newcastle, so that a Care4Care member local to her will look after her. Alternatively, you might be worried about the life of your partner after your own death. So, you save up Care Credits and leave them to your partner, gaining peace of mind that your husband or wife will be supported for if they outlive you.

One of the strengths of the scheme is that it is a way of people caring for those around them and providing for their own future without depending on financials savings or pension schemes. Everyone has something to offer, and everybody's time is valued as equal.

8.95 The Group is not recommending that these initiatives be exactly replicated throughout Cheshire East but simply drawing attention to a range of best practice from which the most appropriate elements can be extracted and applied. Indeed, the Group is also aware of an existing framework in Cheshire

East including Lifestyle centres and Integrated Local Teams (working out of CGP clusters) which could be aligned to such a principle.

8.96 The Group has a strong belief that co-ordinating social care along the lines of the Danish Principle will bring about the best outcomes for the older population of Cheshire East and would suggest that a pilot is commissioned to test the efficacy of the model.

9.0 Managing the Social Care Market

9.1 Whilst the thrust of this report has been to suggest an incremental move away from funding acute high end care and instead facilitate more preventative, community based and delivered care, there will always be a need for residential and nursing homes. The Group was interested therefore in how the Council could best maintain a good supply of quality beds in what has become a tumultuous market.

9.2 It became clear early on that there is no easy solution to this as the Council is struggling to increase the amount paid to care homes with care homes themselves unable to stabilise increasing overheads without affecting the quality of care.

9.3 Once again therefore, the levers that the Council has to protect quality and supply in the market are limited. In trying to maintain a supply of beds, it is easy to see how the debate quickly turns to attempting to find efficiencies in existing contracts. The problem with this is that the more the quality of provision is forced down, the more demand can increase as people's needs quickly descend into more complex territories. Any attempt to find efficiencies also favours the larger care home providers who can use economies of scale to reduce overheads. This causes a potential issue for supply as a market with a few large care homes is much more vulnerable than a market with a larger number of smaller care homes.

9.4 In a scenario where funding is reducing or remaining stagnant whilst costs are going up, it is clear that the only way to keep supply and quality to a sufficient level is to reduce demand. The Group was pleased to note that the Council has already had some success in achieving this. The number of those in receipt of state funded care in Cheshire East has not expanded in line with the growth in the wider older people's population. The service must be congratulated for this. Despite this success, there is always the danger that the ticking demographic time bomb detonates, leaving the Council beyond its capability to manage.

9.5 The Group believes that there are a couple of strategies that the Council could pursue in terms of better managing the market in order to reduce demand.

9.6 *Addressing Self Funder migration.*

9.7 Most commentators agree that in both the short and long term the number of self funders of care will grow. The numbers of people who self fund their care provision is primarily influenced by the relationship between state funding and individual wealth.

9.8 Therefore, numbers may rise through: tighter eligibility criteria, increased charging, less state funding of community organisations, more people having

direct payments and through people who are eligible, topping up their provision from their own, or their families', means. However, a major concern for local authorities, of which Cheshire East is no exception is that there is an increasing number of people who currently self fund their care home placements, migrating over to being council funded when the value of their investments diminish or through increased longevity and spending down capital assets.

9.9 It is difficult to know exactly how serious a problem this is, mainly due to the fact that estimating the amount of people self funding is an art rather than an exact science. Without any knowledge of who is out there and how they are funding their care it is also difficult to predict how many people will 'fall into' Council funded care year on year.

9.10 Whilst it is difficult to give any precise figures, the Council does (This needs checking) have intelligence that 15% of those people presenting for Council funded care in 2011/12 were returning self funders – cost implication of this?

9.11 In terms of managing demand therefore, it is in the Council's interest to reduce the amount of self funders who are migrating to Council care. The Group spoke to Councillor Don Stockton who used to manage a residential care home to gain an insight on the possible strategies that the Council could use to mitigate this issue.

9.12 Councillor Stockton outlined two main issues:

i) That private care homes allow third party 'top ups' when an individual runs out of their own capital. It was asserted that this 'top up' skewed the market as it provides a Council subsidy to the family and keeps residents in a placement with an artificially high cost. If the 'top up' was restricted it would provide an incentive to private care homes to extend the resident's capital over a longer time period thereby reducing the burden on the Council.

ii) That it is in the interest of private care homes to accept residents before they are ready. It was explained that with Council funded care, residents are assessed and placed appropriately but with private care, homes were incentivised to accept 'healthier' residents as they would pay for care over a longer time period. The longer residents are in residential care, the more likely it is that their capital will be reduced to the extent that they will need to migrate to Council funded care. It was suggested that if there was a standardised assessment, it would prevent people from entering care prematurely.

9.13 Whilst the Group was concerned about these issues, it was queried what power the Council has to do something about it. Clamping down too harshly on care homes with clauses in contracts could potentially upset the market balance, possibly incurring significant consequences for the Council. Indeed,

there is no way the Council could fill the void left by a number of private care homes closing despite having a statutory obligation to do so.

9.14 The Group did conclude however that it is in the interest of both the private care homes and the Council to work together to extend the amount of time people self fund their care. This is because it keeps care homes receiving more money than the Council rate and for the Council; it reduces the burden of extra people needing funded care.

9.15 One way this could be achieved would be for the Council to open a dialogue with private care homes about information sharing. Providers are an important source of intelligence about the size and characteristics of the local self-funding market and therefore they could potentially take the following steps to improve the situation:

i. Flag up to the Council when an individual has presented for care so that intelligence can be gathered as to the potential size and characteristics of the self funders market.
ii. Refer an individual to the Council for independent financial advice in managing their resources both when they present for care and when they are already in receipt of care with depleting resources.

9.16 The Council could also take the following steps for improvement:

i. To help foster positive relationships with private care homes, there is a need to work with care providers to ensure that their cash flow is improved. Whilst the Council cannot afford to increase the money given to care homes, it could help in other ways such as reducing their administration costs by improving the efficiency of the payment process
ii. Ensure that customer facing staff are recording all contacts (and providing people with accessible, accurate and appropriate information and advice) so that the Council can monitor the current self defined needs of self-funders and the nature of these contacts.
iii. Improve the basic advice and information given to self funders so that it goes beyond simply a list of care homes. Self-funders often struggle to navigate the care pathway, and to understand the financial implications of different options. People need help to assess the suitability and quality of the care options available to them and it is important that local information and data are designed to meet these consumer requirements. The Group was pleased to note that the Council has developed a partnership with Age UK to provide independent financial advice and has established a website to offer further 'money management' advice. With reference to the earlier point, providing good quality financial advice should be something that is embedded in the practice of all customer facing staff. There is also

the opportunity to present the opportunities that extra care housing presents within this context.

iv. Look to establish an extensive media campaign to try and get people of all ages but particularly those 50+ thinking about how they will fund their future care. It was noted that there needed to be a considerable shift in culture in terms of getting people to understand that the Council will not fund social care for a number of people in their old age. This could be targeted at those residents who were not asset rich.

v. Explore providing an annuity product that would help people to provide for their care in old age.

vi. Explore helping residents to rent out their home so that the rental income could be used to offset care costs whilst maintaining a capital asset for the family. In doing so the Council would need to ensure that the rental agreements were short term so that a deferred charge agreement[21] could be paid off within an adequate timescale. This could also be achieved through the Council's leasing scheme for empty homes (in development), in which a management company (e.g. Registered Provider) would take on the management of the property, with a guaranteed rental income for the owner for the duration of the agreement. As the Council is not a stock-holding authority this would need to be in partnership.

vii. Making sure that the deferred charge scheme is robust by firstly establishing a framework for when people have to liquidate an asset in order to pay off a deferred charge agreement and secondly ensuring that people sign up to the agreement before it is granted. The Group was informed that this had not always been the case in the past.

viii. Work with Age UK by possibly joint funding a welfare advisor in order to ensure that people are receiving the benefits to which they are entitled. This will improve people's cash flow and possibly help them to remain a self funder for longer. The importance of this was demonstrated by the fact that there is a 40% under claim figure for some parts of Cheshire East – one of the worst figures in the country. The benefits of helping people to claim benefits was demonstrated by Age UK Cheshire East as it was noted that they had helped older people gain over £1 million in previously unclaimed benefits in 2010.

9.17 Exploring and understanding the issue of returning self funders has been a frustrating exercise for the Group as it has been difficult to gain access to the numbers involved. It is understood that this intelligence is not readily available as it is difficult to accurately predict the 'known unknowns'. However, there are ways in which the Council could improve this and some of these have been outlined in the points noted above – including trying to get information from private care homes and training customer facing staff to report on contacts. There are also examples of academic work which has

[21] Under this scheme the difference between the resident's assessed contribution and the accommodation charge would be paid by Cheshire East Council. This "deferred contribution" would then be secured by a charge on the resident's property. The resident would still be required to contribute income and other assets towards their fees (assessed contribution).

been completed by the Institute of Public Care at Oxford Brookes University[22] to estimate the number of self funders in England.

9.18 The Group would assert that it is vital that the Council has better intelligence on the numbers of self funders in Cheshire East. Without this, the Council will find it difficult to plan strategically to mitigate the potential demand that returning self funders might bring. Indeed, it is suggested that the Council look to commissioning a piece of research, perhaps in conjunction with a local university, to map the number and characteristics of self funders in Cheshire East.

[22] Estimating the number and distribution of self-funders of care in England - a quantitative study from the Institute of Public Care at Oxford Brookes University – December 2010.

Appendix 1:

Supporting Carers: The Case for Change
Analysis of the document and how it affects Cheshire East.
(Job: PSI SR 0187)

Introduction

The Princess Royal Trust for Carers and Crossroads Care produced a joint document entitled **Supporting Carers. The Case for Change** which was accompanied by a presentation from the report author Gordon Conochie to Lucia Scally on 2 December 2011.
This paper

- provides an analysis of the financial side of the document, including
- updating some of the quoted figures to incorporate 2010/2011 statutory returns and
- provides some modelling around alternative conversion rates of residential usage to Care at Home
- considers whether the consequent increase in Care at Home is reasonable
- considers the impact on the market of such a transformation of residential usage versus Care At Home

Analysis

The original document suggested the following costs and savings for Cheshire East (in appendix 5 of the document).

Table 1

Increased expenditure on carers	Increased expenditure on Care at Home	Decreased expenditure on residential care	Overall savings
£926,020.00	£3,766,612.18	£8,634,200.00	£3,941,567.82

However, there was an error in the calculation of the second column (explained below) and the revised figures as supplied by Gordon Conochie (email to Louisa Ingham on 18 January 2012) are as follows.

Table 2

Increased expenditure on carers	Increased expenditure on Care at Home	Decreased expenditure on residential care	Overall savings
£926,020.00	£4,708,265	£8,634,200.00	£2,999,915

This was based on three factors –

1. A reduction in residential weeks based on the balance of each Local Authority's ratio of residential to home care provision
2. These weeks were then provided as home care at an above-average rate
3. These weeks were additionally funded at £50 per week of support to carers.

In Cheshire East, the calculations were worked as follows.

a) A reduction of 20% in residential weeks was considered possible. This is based on a ratio of residential weeks to Care at Home weeks. As Cheshire East had a ratio between 70% and 95% (in fact 90.63%), the 20% figure has been applied.

   Total number of residential weeks for year 2009/10 (reported in PSS EX1 return) = 92,602. Therefore, 20% of these weeks would be 18,520.4 weeks. The unit cost from PSS EX1 for Residential / Nursing Care was £466.20 per week. Savings on Residential Care would thus be 18,520.4 weeks x £466.20 per week = £8,634,200 (approx.)

b) Increased home care costs are calculated as 25% above the average weekly cost. The figures for home care costs were taken from the RAP P2S home care as at 31 March (number of clients), multiplying it by 52 to give an annual number of client weeks and then dividing that into the expenditure for home care in 2009/10 from PSS EX1. For Cheshire East, these figures were 1965 recipients x 52 weeks = 102,180 client weeks against £20,781,000 expenditure giving a unit cost of approximately £203.38 per week.

   In the 2009/10 PSS EX1, Cheshire East did not give a unit cost figure for Home Care (the total number of home care hours in the year was a voluntary item and one quarter of councils did not complete a figure). Therefore, the method used by the author of the paper was to use the RAP figures for one week and extrapolate. This seems a reasonable basis to use.

   However, the unit cost that had been calculated (£203.38 per week) was then inflated by 25%, giving (rounded) £254.22 per week. When this is applied to the 18,520.4 weeks, a figure for increased home care of £4,708,265 is reached. (**Note that in the first cut of figures the 25% increase in home care costs had not been applied – for any LA not just Cheshire East and hence the savings were overstated. This was corrected in the email sent to Louisa Ingham on 18 January 2012).**

c) Allowing £50 per week for each of these weeks gives £926,020 increased expenditure on carers.

2010/11 PSS EX1

Since the document was produced, the NHS Information Centre has published the 2010/11 figures for PSS EX1 (as a provisional release at this stage). It is therefore possible to update the figures in the document with more recent information than had been available at the time it was written.
Updating the Cheshire East figures using 2010-11 PSS EX1 information gives the following.

Table 3

Residential weeks decreased by	Increased expenditure on carers	Increased expenditure on Care at Home	Decreased expenditure on residential care	Overall savings
21,841	£1,092,038	£7,726,341	£11,469,250.00	£2,650,871

As the ratio of residential care weeks to home care weeks was 134% for 2010/11 (compared to 91% in 2009/10), the calculation in the spreadsheet tells us to use a potential 25% rather than 20% for the number of residential weeks that can be converted to home care weeks. Hence, this would equate to 21,841 weeks.
The number of weeks we report in the PSS EX1 return is a total of residential and nursing for both temporary and permanent provision. It is assumed that this proposal could save temporary (respite) and permanent admissions and the figures have therefore not been disaggregated any further. Around 11% of the residential and nursing weeks in 2010/11 were for temporary stays.
Given there a number of assumptions in the spreadsheet, it is appropriate that we model some of these assumptions and consider the impact and the potential savings with some alternative scenarios.

Modelling.

Let us assume that, rather than the 25% conversion of residential weeks to home care suggested by the 2010/11 ratio, only 10% / 15% / 20% is possible.
At 10% reduction in residential usage

Table 4

Residential weeks decreased by	Increased expenditure on carers	Increased expenditure on Care at Home	Decreased expenditure on residential care	**Overall savings**
8736	£436,815	£3,090,536	£4,587,700.00	**£1,060,349**

At 15% reduction in residential usage
Table 5

Residential weeks decreased by	Increased expenditure on carers	Increased expenditure on Care at Home	Decreased expenditure on residential care	**Overall savings**
13,104	£655,223	£4,635,805	£6,881,550	**£1,590,523**

At 20% reduction in residential usage

Table 6

Residential weeks decreased by	Increased expenditure on carers	Increased expenditure on Care at Home	Decreased expenditure on residential care	**Overall savings**
17,473	£873,630	£6,181,073	£9,175,400	**£2,120,697**

The next assumption is around home care. A unit cost figure has been taken and inflated by 25% "because needs are likely to be greater than average" (Appendix 4). However, it is likely that this is a conservative estimate as a person coming from residential care or being likely to have gone into residential care were it not for this scheme is likely to have a large care package, not just one that is 25% above the average.

What is an average care package? Here are three measures.

(i) We know from PSS EX1 that our unit cost per hour was £23.10 for home care. Worked against a weekly unit cost of £282, this equates to an average package of 12.2 hours.

(ii) This seems in line with industry averages. The UK Home Care Association has quoted an average of 12.4 hours across England.

(iii) Finally, PSS EX1 total home care in 2010/11 for all councils (totals of columns CX + CY) gives 197,744,245 hours in the year. Meanwhile, the RAP P2S total clients for the last week in the year extrapolated (Page1, row 11, column 2 + page 3, row 11, column 2) = 319,315 x 52 = 16,604,380 hours. This gives an average of 11.91 hours per client. (The equivalent figures for Cheshire East are 798,280 divided by (1260 x 52) = 798,280 / 65,520. Average = 12.18 hours.

Therefore, this model proposes that a person could be supported at home on 25% above the average of 12 hours – thus a package of 15 hours (2¼ hours per day). We must assume that these will be large care packages and these may typically require four home care calls per day - 21 or 28 hours per week may be more likely. Thus, we should perhaps consider that these packages would need 30%, 40%, 50% increases in home care costs rather than 25%. This is a modest assumption as these increases would assume packages of 15.6, 16.8 and 18 hours per week respectively.
Expanding the tables from above
At 10% reduction in residential usage

Table 7

	Increased expenditure on Care at Home at 25% above unit cost	At 30% above unit cost	At 40% above unit cost	At 50% above unit cost
Increased expenditure on carers	£436,815	£436,815	£436,815	£436,815
Increased expenditure on Care at Home	£3,090,536	£3,214,158	£3,461,401	£3,708,644
Decreased expenditure on residential care	£4,587,700	£4,587,700	£4,587,700	£4,587,700
Overall savings	**£1,060,349**	**£936,727**	**£689,484**	**£442,241**

At 15% reduction in residential usage

Table 8

	Increased expenditure on Care at Home at 25% above unit cost	At 30% above unit cost	At 40% above unit cost	At 50% above unit cost
Increased expenditure on carers	£655,223	£655,223	£655,223	£655,223
Increased expenditure on Care at Home	£4,635,805	£4,821,237	£5,192,101	£5,562,966
Decreased expenditure on residential care	£6,881,550	£6,881,550	£6,881,550	£6,881,550
Overall savings	**£1,590,523**	**£1,405,091**	**£1,034,226**	**£663,362**

At 20% reduction in residential usage

Table 9

	Increased expenditure on Care at Home at 25% above unit cost	At 30% above unit cost	At 40% above unit cost	At 50% above unit cost
Increased expenditure on carers	£873,630	£873,630	£873,630	£873,630
Increased expenditure on Care at Home	£6,181,073	£6,428,316	£6,922,802	£7,417,287
Decreased expenditure on residential care	£9,175,400	£9,175,400	£9,175,400	£9,175,400
Overall savings	**£2,120,697**	**£1,873,454**	**£1,378,968**	**£884,483**

At Gordon's 25% reduction in residential usage.

Table 10

	Increased expenditure on Care at Home at 25% above unit cost	At 30% above unit cost	At 40% above unit cost	At 50% above unit cost
Increased expenditure on carers	£1,092,038	£1,092,038	£1,092,038	£1,092,038
Increased expenditure on Care at Home	£7,726,341	£8,035,395	£8,653,502	£9,271,609
Decreased expenditure on residential care	£11,469,250	£11,469,250	£11,469,250	£11,469,250
Overall savings	**£2,650,871**	**£2,341,818**	**£1,723,711**	**£1,105,603**

Therefore, in all the above scenarios, we have looked to consider where the costs / savings may be different to those envisaged in the paper. Using a range of 10% -

25% for the reduction in residential usage and a range of 25% - 50% for the increase in home care costs, the savings are as follows.

Table 11

	INCREASED HOME CARE EXPENDITURE			
DECREASE IN RESIDENTIAL USAGE	25%	30%	40%	50%
10%	**£1,060,349**	**£936,727**	**£689,484**	**£442,241**
15%	**£1,590,523**	**£1,405,091**	**£1,034,226**	**£663,362**
20%	**£2,120,697**	**£1,873,454**	**£1,378,968**	**£884,483**
25%	**£2,650,871**	**£2,341,818**	**£1,723,711**	**£1,105,603**

These range from £442,000 to £2.65 million. Thus, the proportion of weeks that can be converted from residential to home care and the increase in home care costs these would bring are crucial in ascertaining what savings could accrue to Cheshire East.

The issue of "Year 1"

It has been assumed here that we will not seek to take residents **from** care homes to support them at home. We would not presently be identifying a "carer" when the person is in a care home and the assumption in the original paper is that a proportion of **admissions** to residential and nursing care can be prevented. In 2010/2011, Cheshire East admitted 560 clients to permanent residential and nursing establishments over the course of the year. If, in the future, we continue to place at that same rate (around 11 clients every week), we will not be converting the full set of residential weeks to home care weeks from week 1. Rather, in Year 1, we will see a gradual implementation of the process as small numbers of persons who would have otherwise gone in to residential care are then supported at home. Let us consider the following theoretical example using some very average numbers.

Table 12

Week	Number of persons considered for residential care	20% supported at home instead	Number of residential weeks saved from then to Year End	Number of residential weeks saved (YTD)
1	11	2 persons	52 x 2 = 104	104
2	11	2 persons	51 x 2 = 102	206
3	11	2 persons	50 x 2 = 100	306
4	11	2 persons	49 x 2 = 98	404
5	11	2 persons	48 x 2 = 96	500
And so on up to the Year End….				
52	11	2 persons	1 x 2 =2	2756

This shows that in the first year, we would only be saving around 2000 – 3000 weeks (and not the 8000 – 21,000 envisaged in the models above). In the second year, we would save 52 weeks for each of these 100+ clients from the first year which would be 5200+ weeks, together with a new cohort of clients for whom we would save 2000 – 3000 weeks. Thus, even by the end of Year 2, we are only just reaching the low estimate of the weeks that we could save.

Indeed, we have calculated that, if we have 560 new admissions in a year, if these clients are admitted at a steady rate through the year and they all stay in care from then to the end of the year, they would account for 14,840 weeks. If we only looked for clients eligible for this process from that group of people, we would either need to be converting a very large percentage of the 560 people to Care at Home (which is of course impractical as many admissions will not be preventable e.g. due to their needs or clients may have no suitable carer by whom they could be supported) or we would be achieving far fewer weeks saving than first thought.
Thus, a point for consideration is the assumption above that we would not be taking residents **from** care homes. If substantial savings are to be made in a shorter time scale, then effort will need to be put into identifying residents in care homes who could be supported at home after all.

The costing model assumes a payment to a carer of £50 per week which is acknowledged to be generous and above any known carer's personal budget (covering email from Gordon Conochie to Lucia Scally 7 December 2011). However, as the costing includes training for the carer together with respite, it does not seem unreasonable and no attempt has been made here to model a lower figure for that item. Further considerations around carers can be found later in this analysis.

Impact on the market for residential care.

The 2010/11 PSS EX1 return shows us that residential and nursing weeks total as follows (all age groups):
Table 13

All Nursing Care	34,715	45% of all Res / Nursing
Residential Care provided by Local Authority	4245	5% of all Res / Nursing
Residential Care provided by Others	38,905	50% of all Res / Nursing

Therefore, 95% of the Residential and Nursing Care is provided by the independent sector. This is 73,620 weeks in 2010/11. It is not measured here as to how many of these weeks are bought as Out of County placements and, conversely, what proportion of residents in Care homes in Cheshire East are from either non-Cheshire East locations or are privately funded placements without any involvement of Cheshire East in the assessment.

It seems reasonable to assume, however, that the 73,620 weeks above is a good estimate of the level of business of the care homes in this local authority. The proposal in the paper by the Princess Royal Trust and Crossroads Care envisages a

transfer of 15% - 25% of the total weeks from the residential sector to Care at Home. This is 2.4 million weeks (or £14.9 billion) across England and, for Cheshire East, it has been calculated at 18,520 weeks in the appendix (£8.6 million). Updating the Cheshire East figure for 2010/11 returns, we would be assuming £11.469 million taken out of the residential sector at 25% conversion rate (21,841 weeks i.e. more than 150,000 bed nights in the year). Using the lowest conversion rate of 10% we have considered in our modelling, we would still have £4.858 million less paid to the residential sector, being 8736 weeks (more than 60,000 bed nights in the year). While the private and voluntary sectors have enjoyed growth over recent years through the shift away from internally-provided residential care and the expansion in the social care market in general, this would be a significant reversal of their business and would need to be carefully discussed with Strategic Commissioning due to the impact it could have.

Impact on the market for domiciliary care.

The converse to the above is that there will be an increase in the provision of domiciliary care of which the private and voluntary sectors will be the beneficiaries. The forecast is that £567.3 million of increased domiciliary care would be commissioned across England and that, in Cheshire East, this would be an increase of £4.7 million in the domiciliary sector. Updating the Cheshire East figure for 2010/11 returns at the same percentages as in the original paper, we would be assuming £7.7 million. Using the various modelling figures, it ranges from £3.1 million to £9.3 million additional domiciliary spend. This is on a budget of £20.78 million at 2009/10 figures (or £18.47 million at 2010/11 figures). Again, this is envisaging a significant impact on the market that would need to be discussed with Strategic Commissioning.

Important factors to consider would be around the availability of the home care workforce and potential bottlenecks around popular times of delivery of care. These issues inevitably arise from such a large increase in hours and it would need to be explored with providers as to whether they believed there was the possibility of sufficient recruitment to meet the demand. (See forecasts from Personal Social Services Research Unit).

Carers.

Underlying the proposal in the paper is the recognition that some service users will be able to remain at home due to the presence of a carer. It is assumed that, in Cheshire East, there is a cohort of service users supported by carers who would be able to benefit from increased support, training and funding such that the service user will be able to remain at home and that the carer will be capable of providing this support.

In Cheshire East, we reported in 2010/11 that there were 1295 carers who had been offered an assessment or review. 305 of these were themselves aged 75 or over. Based on national trends, three-quarters of carers live with the cared-for person and one-third of carers spend 100 or more hours per week caring for a person. In recent

years, we have had a high proportion of carers who declined an assessment or review (around 20%).

However, the performance in 2011/12 has been such that there has been a large increase in the number of carers who have been offered an assessment. By Quarter 3, 2964 carers had been offered an assessment, suggesting that in the full year, the numbers involved will be substantially greater than in previous years. Also, the number of those who declined an assessment has fallen to 10% which provides a better basis for identifying carers and their needs, including those who may be able to support an initiative such as this.

We identified in
Table 4 to
Table 6 that 8736 to 21,841 weeks would be converted to Care at Home. In a full year, this would be from approximately 160 to 420 carers (but noticing the Year 1 scenario outlined above, the numbers would be smaller than this at first). Once we have a full cohort of perhaps 300-400 carers receiving this support, this will be only a subset of the 2964 or more carers that we have identified. Therefore, we may encounter issues over differential support for carers. Note that there may be carers providing high levels of care for persons who **do not** satisfy either the criteria for residential care admission or the criteria by which they would have been admitted had it not been for this scheme. The support given by these carers is likely to be no less in terms of quality, quantity or importance to the service user's wellbeing than those we have identified for this enhanced carer payment and there may be issues over fairness and differentials in financial support.
It has been found through the Adult Social Care Survey that nationally more than 80% of carers are satisfied with breaks (whether short breaks of up to 24 hours or longer breaks) and the increased support for carer respite this proposal envisages would certainly appear to be a welcome development. It is also necessary to consider what the impact would be on respite provision for an increased group of carers or cared-for persons.

Similarly, the proposal presumes a large increase in training provided to carers. Practicalities that would need to be considered include

- what types of training will be required
- who will identify what training for what carers as there will be different competencies, circumstances and requirements
- what capacity there is among training organisations for a large-scale increase in carer training,
- how this training would be funded (direct funding of providers versus funding through Carer Direct Payments),
- possible increased respite of the cared-for person during carer training periods

The proposal also seems to bring an extra process for Assessment and Care Management staff around identifying a class of eligible client who would meet these criteria. Where we would previously have considered

> "need this person go into residential care or can they be supported at home through a package of care?"

We would now consider

> "if this person can be supported at home through a package of care, *would they have gone into residential care had this additional funding for the carer not been available?*"

Thus, we would need to know which client has a carer for which we would be offering this package of care including the enhanced carer payment. How do we identify the carers in question e.g. would the number of hours of care provided be a factor, would we have to build a matrix to assess the threshold or do existing processes suffice?

A further consideration would be whether some existing carers qualify or whether this is only applicable to new assessments.

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Overview and Scrutiny Review

Adult Social Care Scrutiny Committee

November 2011 – May 2012

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