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MANCHESTER CITY COUNCIL

Health Scrutiny Committee

Date: Tuesday, 4 September 2018
Time: 10.00 am
Venue: Council Chamber, Level 2, Town Hall Extension

Everyone is welcome to attend this committee meeting.

There will be a private meeting for Members only at 1.30pm in Committee Room 6 (Room 2006), 2nd Floor of Town Hall Extension

Access to the Council Chamber

Public access to the Council Chamber is on Level 2 of the Town Hall Extension, using the lift or stairs in the lobby of the Mount Street entrance to the Extension. That lobby can also be reached from the St. Peter's Square entrance and from Library Walk. **There is no public access from the Lloyd Street entrances of the Extension.**

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Membership of the Health Scrutiny Committee

Councillors - Farrell (Chair), Battle, Clay, Curley, Holt, S Lynch, Mary Monaghan, O'Neil, C Paul, Reeves, Riasat, Smitheman, C Wills and J Wilson

Agenda

1. Urgent Business
To consider any items which the Chair has agreed to have submitted as urgent.

2. Appeals
To consider any appeals from the public against refusal to allow inspection of background documents and/or the inclusion of items in the confidential part of the agenda.

3. Interests
To allow Members an opportunity to [a] declare any personal, prejudicial or disclosable pecuniary interests they might have in any items which appear on this agenda; and [b] record any items from which they are precluded from voting as a result of Council Tax/Council rent arrears; [c] the existence and nature of party whipping arrangements in respect of any item to be considered at this meeting. Members with a personal interest should declare that at the start of the item under consideration. If Members also have a prejudicial or disclosable pecuniary interest they must withdraw from the meeting during the consideration of the item.

4. Minutes 5 – 10
To approve as a correct record the minutes of the meeting held on 17 July 2018.

5. Our Manchester Homecare 11 – 24
Report of the Executive Director Strategic Commissioning and Director of Adult Social Care

This report describes a proposed new model of homecare – 'Our Manchester homecare'. This report further sets out the key current issues for our homecare recipients and providers and explains why the existing model needs to change. The new model of homecare will go out to tender later this month.

6. Manchester Public Health Annual Report 2018 25 - 60
Report of the Director of Population Health and Wellbeing/Director of Public Health

As part of the statutory role of the Director of Public Health there is a requirement to produce an annual report on the health of the local population. This report can either be a broad overview of a wide range of public health programmes and activities or have a single issue focus. The 2018 report has a single issue focus on air quality.

7. Local Government Association's Adult Social Care Green Paper: Draft Manchester input 61 - 158

Report of the Executive Director of Strategic Commissioning and Director of Adult Social Care

This paper is Manchester's draft input to the Local Government Association's green paper on adult social care and wellbeing, 'The lives we want to lead'. The period for consultation ends on 26 September 2018.

8. Overview Report 159 – 176

Report of the Governance and Scrutiny Support Unit

This report includes details of the key decisions due to be taken that are relevant to the Committee's remit as well as an update on actions resulting from the Committee's recommendations. The report also includes the Committee's work programme, which the Committee is asked to agree.

Information about the Committee

Scrutiny Committees represent the interests of local people about important issues that affect them. They look at how the decisions, policies and services of the Council and other key public agencies impact on the city and its residents. Scrutiny Committees do not take decisions but can make recommendations to decision-makers about how they are delivering the Manchester Strategy, an agreed vision for a better Manchester that is shared by public agencies across the city.

The Health Scrutiny Committee has responsibility for reviewing how the Council and its partners in the NHS deliver health and social care services to improve the health and wellbeing of Manchester residents.

The Council wants to consult people as fully as possible before making decisions that affect them. Members of the public do not have a right to speak at meetings but may do so if invited by the Chair. If you have a special interest in an item on the agenda and want to speak, tell the Committee Officer, who will pass on your request to the Chair. Groups of people will usually be asked to nominate a spokesperson. The Council wants its meetings to be as open as possible but occasionally there will be some confidential business. Brief reasons for confidentiality will be shown on the agenda sheet.

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Smoking is not allowed in Council buildings.

Joanne Roney OBE
Chief Executive
3rd Floor, Town Hall Extension,
Lloyd Street
Manchester, M60 2LA

Further Information

For help, advice and information about this meeting please contact the Committee Officer:

Lee Walker
Tel: 0161 234 3376
Email: l.walker@manchester.gov.uk

This agenda was issued on **Friday, 24 August 2018** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 6, Town Hall Extension (Mount Street Elevation), Manchester M60 2LA

Health Scrutiny Committee

Minutes of the meeting held on 17 July 2018

Present:
Councillor Farrell – in the Chair
Councillors Battle, Clay, Curley, Holt, Mary Monaghan, O'Neil, Reeves, Riasat, Wills and Wilson

Councillor Craig, Executive Member for Adults, Health and Wellbeing

Nick Gomm, Director of Corporate Affairs, Manchester Health and Care Commissioning
Lynne Stafford, Chief Executive, The Gaddum Centre
Ed Dyson, Executive Director of Planning and Operations, Manchester Health and Care Commissioning
Peter Blythin, Director of the single hospital service programme
Jo Purcell, Deputy Director of Strategy, Northern Care Alliance

Apologies: Councillors Lynch, Paul and Smitheman

HSC/18/30 Minutes

The minutes of the Health Scrutiny Committee meeting of 19 June 2018 were submitted for approval. Councillor O'Neil requested that his apologies be recorded.

Decision

To approve the minutes of the meeting held on 19 June 2018 as a correct record subject to the above amendment.

To note the minutes of the Public Health Task and Finish Group meeting held on 26 June 2018.

HSC/18/31 The Our Manchester Carers Strategy

The Committee considered the report of the Executive Director Strategic Commissioning that provided Members with the interim "Our Manchester Carers Strategy". The report set out the initial measures to drive service improvements and the on-going development of this strategy on a co-produced basis in partnership with Manchester's Carers, their support organisations and the wider Manchester Community.

The Executive Director Strategic Commissioning referred to the main points of the report which were:-

- Describing the context for the development of the strategy;
- Findings from Manchester Carers Services Review;

- A description of the Statement of Intent that would form the basis of the Manchester Carer Charter and would underpin the forward development of support services;
- Strategic Objectives;
- The Our Manchester Carers Action Plan;
- Information on the establishment of an Our Manchester Carers Partnership Group;
- Development of an Our Manchester Carers Charter;
- Development of a "Single Point of Contact" and revised assessment process; and
- A timeline and schedule for the development of the underpinning framework that would support the Our Manchester Carers Strategy.

The Committee also received a presentation from the Chief Executive, The Gaddum Centre entitled the 'Manchester Carers Services Review and Strategic Approach to developing an Our Manchester Carer Friendly City'. The presentation was accompanied by a number of short videos that described a range of carer's experiences.

Some of the key points that arose from the Committee's discussions were:-

- Welcoming the report and supporting the approach adopted to develop the interim "Our Manchester Carers Strategy";
- A Communications Strategy, including the use of Social Media, similar to the Fostering and Adoption campaign should be designed to promote the importance of carer's and the services and support that is available to them;
- The impact of welfare reform on carers and the provision of Welfare Advice services;
- The importance of support for carers within specific community groups, e.g. the LGBT community;
- Had any research been undertaken to study the impact on a carers mental health for those caring for people with mental health condition;
- Did Manchester Move recognise caring as work;
- What groups made up the Carers Network;
- What were the time lines for delivering this strategy;
- Respite care appeared to be hard to access and inconsistent;
- Employers played an important role in supporting those staff with caring responsibilities; and
- Who would be responsible for training volunteers?

The Chief Executive, The Gaddum Centre informed the Members that the Carers Network comprised of the twenty organisations commissioned to provide carers support in Manchester. She described that the Network had a website and an active Twitter account and encouraged partners to retweet their messages. She said that affiliated groups could attend meetings of the Network, and the intention was to expand the Network and provide outreach to establish links with traditionally hard to reach communities. She said that a recent event had been held with the LGBT Foundation to identify carers.

The Chief Executive, The Gaddum Centre described The Our Manchester Carers Strategy as a sound foundation to deliver improved services and support for carers in Manchester. She said that volunteers would be trained by Team Leaders in the local teams. She further informed Members that work was currently ongoing at a Greater Manchester level to develop an Employers Charter to recognise the role of carers.

In response to the question asked regarding research undertaken regarding the mental health of carers who cared for a person with mental health she said that she would investigate this and notify the Committee.

The Executive Member for Adults, Health and Wellbeing said that strategy recognised the important role that carers delivered across the city and she was committed to delivering this important piece of work. She said that the strategy had been developed with the voice of the carer at its centre and she welcomed the comments from the Health Scrutiny Committee. She said that a bespoke communications strategy would be instigated when the strategy was formerly launched. She commented that austerity and welfare reform had a significant and detrimental impact on carers, and the increased demand on advice services reflected the roll out of Universal Credit. She said that Manchester Health and Care Commissioning had recently invested £0.5m to install dedicated phone lines in GP practices so that people could contact the Citizens Advice Bureau directly for help and support.

The Executive Member for Adults, Health and Wellbeing said that she acknowledged the comments made regarding respite care and options were being considered as to how this was to be delivered and improved in the future. She also informed the Committee that she would investigate the question raised by Member regarding Manchester Move to ensure that carers were recognised as workers. She further informed the Committee that work was emerging to respond to specific groups, such as extra care housing for older LGBT citizens.

Decisions

The Committee:-

1. Welcomes the report and supports the co-design of the strategy with the voice of carers at the centre of this; and

2. Requests that an update report be submitted for consideration at an appropriate time.

HSC/18/32 Single Hospital Service progress report

The Committee considered the report of the Executive Director of Planning and Operations Manchester Health and Care Commissioning (MHCC) that provided Members with an update on the delivery of the Single Hospital Service (SHS).

The Executive Director of Planning and Operations, MHCC referred to the main points of the report which were:-

- A description of the strategic context of the SHS;
- The benefits achieved following the establishment of the Manchester University Hospitals NHS Foundation Trust (MFT) in 2017;
- An update progress with transfer of North Manchester General Hospital NHS Trust (NMGH) into MFT and the associated strategy.

Some of the key points that arose from the Committee's discussions were:-

- What impact would the financial deficit at Pennine Acute Trust (PAT) have on the Manchester University Hospitals NHS Foundation Trust?
- Did the recent reports of the closure of an operating theatre represent asset stripping at NMGH;
- Would transport be provided between hospital sites following the transfer of North Manchester General Hospital NHS Trust (NMGH) into MFT;
- Patients would need to be reassured that NMGH was a safe hospital;
- Members expressed their frustration at the pace of the transfer of NMGH into MFT;
- Members reported that they and their constituents regularly encounter poor experiences at NMGH; and
- Staffing levels continued to be an issue at NMGH and the impact this had on continuity of care and patient confidence in the site.

The Executive Director of Planning and Operations, MHCC said that the PAT would model how much of the financial deficit would be attributed to NMGH. He said that increased efficiencies would be achieved at the site following the merger by improving the estate and reducing the reliance on agency staff. He said that the merger of NMGH into the SHS would continue to make MFT an attractive place to work for health professionals. He said that there was no evidence of asset stripping at the site and any change would have to be agreed by commissioners. He said that the requirement of NHS Improvement that this transaction, and the Fairfield, Rochdale and Royal Oldham hospitals transfer to the Salford Royal would be simultaneous had added to the complexity of this piece of work.

The Deputy Director of Strategy, Northern Care Alliance said the operating theatres that had been closed recently had been necessary and had impacted on a small number of patients. She said that the Leadership Team at NMGH were dedicated to improving the site and acknowledged that communications needed to be improved so as to reassure the local population. The Executive Director of Planning and Operations, MHCC reassured the Committee that irrespective of the planned merger, due to be completed by April 2020, the site would continue to be challenged to improve. He said this was evidenced by the findings of the recent CQC inspection.

In response to the Members comments that communications needed to be improved so that local Members and residents were aware of any developments at NMGH in a timely manner, the Executive Member for Adults, Health and Wellbeing suggested that the Committee received a bi monthly update as part of the Health and Wellbeing Update report. Members endorsed this recommendation.

A Member requested that a report be added to the work programme that provided information on the financial implications of the SHS, and in particular what impact the

deficit at North Manchester General Hospital would have on the Manchester Locality Plan.

Decisions

The Committee:-

1. Notes the report and the progress described on the delivery of the Single Hospital Service;

2. Requests that a bi monthly update be provided to the Committee via the Health and Wellbeing report; and

3. Requests that a report be added to the work programme that provides information on the financial implications of the Single Hospital Service, and in particular what impact the deficit at North Manchester General Hospital would have on the Manchester Locality Plan.

HSC/18/33 Overview Report

A report of the Governance and Scrutiny Support Unit which contained key decisions within the Committee's remit and responses to previous recommendations was submitted for comment. Members were also invited to agree the Committee's future work programme.

A Member requested that a report on the actions taken with Care Homes following a rating of Inadequate or Requires Improvement by the Care Quality Commission be included on the work programme.

Decision

To note the report and approve the work programme subject to the above amendment.

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Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 4 September 2018

Subject: Our Manchester Homecare

Report of: Executive Director Strategic Commissioning and Director of Adult Social Care

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Summary

Our ambition is to put personal care at the heart of care - to be more flexible, to be able to deliver agreed outcomes that are better for the citizen. We'll get out of the way and trust providers to get the job done, while making sure we have checks and balances so we can make sure our residents are safe. We'll have a relentless focus on spotting the 'not quite right' early - those issues that have the potential to require escalation or threaten outcomes for the recipient of care.

This report describes a proposed new model of homecare – 'Our Manchester homecare'. In order to achieve our ambition, it is important this model meets the needs of people who use our services and help support family carers. The new model is therefore:

- focussed on the outcomes that matter to people
- strengths based, starting with the positive what people can do for themselves and supporting people build or maintain skills and confidence
- place-based: matched to the footprint of Integrated Neighbourhood Teams
- centred on continuity of care: the top priority of people using homecare
- predicated on building a trusted partnership with homecare providers

This report sets out the key current issues for our homecare recipients and providers and explains why the existing model needs to change. The new model of homecare will go out to tender later this month.

Recommendations

Committee are asked to endorse the proposed new model of homecare for the people of Manchester.

Wards Affected: All

Alignment to the Our Manchester Strategy Outcomes (if applicable)

Manchester Strategy outcomes	Summary of how this report aligns to the OMS
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	
A highly skilled city: world class and home grown talent sustaining the city's economic success	This service will drive the development of a more highly skilled workforce which can progress through the health and care system
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	The new Our Manchester Homecare service has a strong social value strand, focussed on recruiting local people and building on their skills and knowledge and those of people using the service
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

Contact Officers:

Name: Dr Carolyn Kus
Position: Executive Director Strategic Commissioning and Director of Adult Social Care
Telephone: 07976 792096
E-mail: carolyn.kus@manchester.gov.uk

Name: Rachel Rosewell
Position: Head of Finance, Adult Social Care and Children's Services
Telephone: 0161 234 1070
E-mail: r.rosewell@manchester.gov.uk

Name: James Binks
Position: Head of Reform and Innovation
Telephone: 0161 234 1146
E-mail: j.binks@manchester.gov.uk

Name: James Williams
Position: Strategic Commissioning Lead
Telephone: 0161 234 3805
E-mail: j.williams4@manchester.gov.uk

Background documents (available for public inspection): None

1.0 Introduction

1.1 Homecare plays an important role in enabling people to live in their home for as long as possible. It offers a preventative approach for people to keep healthy and have a fulfilling quality of life.

1.2 Manchester has always been proud to be ambitious; unwavering in its commitment to help those who need an extra helping hand. This was evident in our commitment to uplift our fee rates and ask our homecare providers to pay their workers the real living wage from April 2018.

1.3 Manchester has always been proud to think big - and on the big challenges facing our society, we're taking big steps to improve outcomes for our residents. One of those challenges is home care.

1.4 Most home care is delivered by private or not-for-profit organisations, not councils; though councils pay for support for some people, depending on their needs and their financial situation. It supports people to remain independent in their own homes and helps people with day-to-day activities like getting up, washing, dressing and eating.

1.5 However, it's more than just the sum of its tasks. It gives people **dignity** and helps them to stay in their own homes, living their own lives. In all the discussions about the reform of adult social care, we should never ever lose sight of the human impact it has for people.

But it could be so much more. We could do so much better. And that's a challenge we should seize with both hands.

1.6 This report sets out a new model of homecare - Our Manchester homecare. The report starts by setting out the key current issues for our homecare users and providers and explains why the model needs to change. The report summarises feedback from homecare users, which has helped shape the design of the new model, alongside extensive engagement with homecare providers, health and social care professionals and frontline care workers, we have also included our commitment to the Ethical Care Charter, expecting providers to offer the real living wage to staff as well as ending zero hours contracts, where appropriate.

1.7 The scope of the new model includes the homecare provided to Manchester residents, we are also taking this opportunity to include residents living in Extra Care schemes and in a second phase we are aiming to include those who qualify for NHS Continuing Healthcare (NHS CHC) funding. The intent is the services will work with and in cohesion with MLCO. This allows us to look at how future services may be delivered as the MLCO develops.

1.8 As part of this procurement we are adding in a requirement for homecare providers to offer a sitting service for carers, paid for through either carers

budgets or personal budgets, via prepaid cards. We are also signalling a forthcoming pilot on Supported Early Discharge from hospital, which aims to guarantee a number of hours of homecare in each neighbourhood, starting in the North, to help people to come home from hospital quickly.

1.9 As we are now in the immediate pre-procurement phase for this service, this report focuses on the high level design of the service, rather than the detail of the commercial, financial and contracting model.

1.10 Our current expectation is that the contract management and future commissioning of homecare will transfer to the Manchester Local Care Organisation by December 2019.

2.0 Background

2.1 *What is homecare?*
Homecare is support and personal care which helps people remain living independently in their own homes. In general terms, care workers go into people's homes and provide support with a range of activities such as helping people get up, have a wash, get dressed and go downstairs. Homecare workers help people prepare food and drink and other activities to facilitate their daily lives.

2.2 Homecare in Manchester is delivered by a range of organisations of different sizes, some private sector companies and some not-for-profit organisations. We currently have a framework of 9 providers and spot purchase from a further 11. We have been operating the same model since 2008.

2.3 During the design phase of the model we undertook a wide range of engagement with public and partner organisations, one of the key pieces of work was the development of detailed data base which enabled us to understand the physical health of individuals in the neighbourhoods but in particular what was causing the most breakdown in packages of care.

2.4 NHS CHC homecare is essentially the same service, funded and commissioned by the NHS on the basis that someone has a primary health need.

2.5 Extra Care homecare is also the same core service, however rather than in peoples own homes this is delivered in one of our Extra Care schemes. Extra Care is retirement housing for people aged over 55. People can rent, own or part own their home within the scheme and use the onsite care provision. We currently have seven schemes in the city and have a programme to increase this substantially in the coming years. People in Extra Care have a mix of care needs or none.

2.6 *Who gets homecare?*
Using our data intelligence pack over the course of 12 months, we were able to determine that 2,700 people in Manchester use homecare commissioned by the Council. At any point in time around 1,700 people use this homecare, and:

- 30% have homecare for more than 3 years
- 81% are over 65 years of age
- People under 65 with a Learning Disability or a mental health issue can also be eligible for homecare
- 80% are white British
- 8.6% are Asian/Asian British (17.1% of Manchester population)
- 43% are supported by an unpaid carer
- 63% are women
- We do not hold complete sexual orientation monitoring information for this cohort (this will be a future requirement)

Around 120 people a year use NHS CHC homecare and 140 Extra Care homecare.

2.7 *What does it cost?*
The Council currently spends £16m a year on home care, the new model of outcomes based working, rather than time and task should enable us to be more efficient in our delivery model, as well as at the same time developing Extra Care and reablement. We are working with colleagues in MHCC to establish the detail of CHC costs and packages of care.

3.0 The case for change

3.1 Health and social care reform is critical to achieving the ambitions for the city, as set out in the Our Manchester Strategy. A progressive and equitable city means people living healthier and more fulfilled lives, with much reduced health inequalities across the city. A liveable and low-carbon city requires resilient places and communities where people can live and age well. A thriving and sustainable city needs a healthier population who are able to work and be more productive in work, with fewer people in poor health not benefiting from economic prosperity. Homecare currently exists in a bubble, with little connection to the wider health and care system, or to the wealth of community and voluntary activity in neighbourhoods which could improve people's social connections and quality of life. When something goes wrong for a person using homecare, homecare workers have no route in to 'the system' to get help or support.

3.2 Extra Care homecare and NHS CHC homecare are essentially the same service as core, or generic homecare and yet we procure them separately, pay different rates and ask for different information from providers, an unnecessary administrative burden both for commissioners and providers. Some Manchester residents will use all three types of homecare as their needs fluctuate.

3.3 The demand pressures on Adult Social Care are entrenched and widely known. The Government has recently consulted on changes to the Adult Social Care Relative Needs Funding Formula used for determining funding to Local Authorities which has been in place since 2005/06. The outcome of the consultation was expected to be released in the summer linked to the Green Paper regarding care and support for older people. It is now expected that this

will be delayed until the autumn and it will likely be 2020/21 before any changes are concluded. Manchester residents cannot wait for the outcome of government proposals before progressing with changes to the homecare model and an effective contract framework.

4.0 Recent developments

4.1 In April 2018 the Council agreed to substantially increase the rate paid for homecare from £13.50 an hour to £15.20. The Council placed a number of conditions on homecare companies in return for this uplift, including that providers should pay their staff a minimum of £8.75 an hour. Anecdotally, some providers have told us that this uplift has made "a massive difference" particularly in their ability to recruit under 25s.

4.2 This fee uplift appears to have, at least in part, helped stabilise the care market in Manchester, and gives us a platform to build on, to start to transform what homecare looks like, how it is delivered, and how we work with our providers to realise the opportunities offered by the integration of health and social care, place based working and the Our Manchester approach.

5.0 Designing a new model

5.1 *Methodology*
We began work on designing a new model of homecare by undertaking a thorough analysis of the people who use homecare, focussing on understanding which other health and care services these people use, how and why. This analysis has given us a deep insight into how effective homecare services have the potential to improve both the quality of life and, in time, the health outcomes of our homecare population.

5.2 The data only provides part of the picture. In designing our service model we have conducted wide and deep engagement with a range of stakeholders:

- people who use homecare and their carers,
- the voluntary and community sector,
- homecare providers,
- health and social care professionals at all levels, and
- other health and social care commissioners, in Manchester and beyond.

5.3 *What matters to people receiving homecare?*
We spoke to people who use homecare, their families and carers. We did this through 12 face to face interviews, 115 telephone interviews and a number of meetings and workshops.

"It works well when they send the same people and this is really important to me. The carers know me by name, they know where everything is and it makes it really easy to have them in my home"

5.4 We asked people to tell us what is working well, what is not working well and what is important to them for the future of homecare services. Across all of our engagement with homecare users, their carers and families, the same themes

came up many times. The feedback we received is summarised below, in the form of 'I statements':

- *Continuity of and quality of care*: I prefer the same paid carers to come regularly as this means I can build a good relationship with them, helping me to feel comfortable. I think of my paid carers as friends and enjoy having a laugh and a chat with them.

- *Reliable service:* with all of the time allocated to me, delivered. I want to know when the carer is coming and to be told if they are going to be late. I want to feel the carer has time for me and I'm not being rushed.

- *Knowing who to contact*: if I have questions or concerns about my care, if my needs change and to find out about other services, benefits, access to equipment etc.

- *Care planning:* I want to be involved in planning my care and for my unpaid carer and family to be involved too – not just at the start but all of the way through. It's my plan and each care worker who comes to my home should know what is in it.

- *Monitoring*: I want to be involved in monitoring of homecare services and so do my carer and family.

- *Personalised*: I want a service that meets my cultural and other needs: knowing what I like to eat, that I might speak a different language and have a particular lifestyle.

- *Training:* I want continuing training and development for paid care workers so I get quality service now and there is a potential career pathway for them.

5.5 *Data – what did it tell us?*
We have taken advantage of health and care integration to look at the whole picture for our homecare users. We have been able to match the records held in the Council's system Micare, with NHS numbers to understand, for the first time, what happens to people who use homecare in the wider health and care system.

5.6 We have used this data to build 12 neighbourhood profiles showing the demography of our homecare users and also their long term health conditions, the frequency of their hospital admissions, how long they stay in hospital and what the reasons are for their admission. This data has given us insight into the potential for a different kind of homecare to deliver a better experience for homecare users, as well as wider benefits for the health and care system.

5.7 Some of the key findings for our homecare population:

- 92% have one or more, and 76% have two or more long term conditions, such as high blood pressure and diabetes

- People who receive homecare are much more likely than the general population to go to A&E and to be admitted to hospital, going to A&E once every 6 months on average, being admitted to hospital once every 8 months on average and then spending an average of 14.8 days in hospital, compared to 4 days for the rest of the population
- Close to 1 in 2 are rated at high or very high risk of an ***emergency*** hospital admission
- The main reasons people are admitted to hospital are respiratory, genito-urinary and circulation problems
- One in five has a confirmed dementia diagnosis and up to a further one in five has been admitted to hospital with dementia related problems

5.8 *Using the data to engage*
We have taken this data and spoken to homecare users and families, homecare workers, professionals from across the health and care system. We have spent dedicated time with small and larger groups of homecare providers. We have used this engagement to first outline a future service model, and then to develop this model iteratively, as we have continued to engage.

5.9 *Learning from other areas*
We have spoken to and shared work with other homecare commissioners across Greater Manchester, learning from their approaches. Whilst there are many common features across the different models being employed in Greater Manchester, the Manchester model is highly distinctive, as it builds on how the city has chosen to progress health and social care integration at a place level.

6.0 How is the new model different?

6.1 The overall purpose of the new homecare service is to enable people to stay at home, living as independently as they can and with the best possible quality of life.

6.2 We also want to:

- Support unpaid carers in the valuable work they do
- Make home care a more attractive career option by improving conditions and career pathways, capitalising on the projected increase in the younger working age population in Manchester
- Improve the sustainability of the health and care system by making homecare an integral part of person-centred care, acting as the “eyes and ears” of the health and social care system, to spot when things aren’t quite as they should be, and take steps to make sure things don’t get worse
- Realise additional social value through this contract

6.3 *Key features of Our Manchester homecare*

6.4 The new model, and way of working, will move homecare away from the current rigid ‘time and task’ model, which describes for providers in detail how many calls they will make each day, for how long, and lists the tasks they will

perform. Instead, homecare workers will be given a “budget” of hours. They will plan with people how they will use these hours to help them achieve the **outcomes** which matter to them most.

6.5 In support of achieving these outcomes, the new service will take a **strengths based** approach. This will mean homecare workers working with people, to help them build or maintain their independence, not doing tasks for them, because it’s quicker and easier.

6.6 As set out in 5.4, homecare users have told us how important it is to them that they get to know their carers. **Continuity of care** also makes working towards outcomes and building on strengths much more achievable. The model depends on support being delivered through a small, core team of care workers, who are known to the homecare user and their family, wherever possible.

6.7 The new service will be properly **place based**. This means a true patch or area based model with providers taking responsibility for picking up all packages of care in their area, including where an Extra Care facility exists, the homecare element of this service, and, in time, NHS CHC Homecare. The neighbourhood ‘lots’ will map on to the 12 neighbourhoods agreed as the basis of health and care integration. Homecare providers and Integrated Neighbourhood Teams will be expected to build relationships, at all levels, facilitated by Link Managers. We are asking providers to have a base in the area they are working in and to focus on recruiting (very) local people to work for them.

6.8 Providers will be able to bid as a partnership or consortium and to **subcontract** some of their work to other providers. Together with a variety of lot sizes, this means this work will be open to a range of provider types and sizes - including those in the voluntary and community sectors. We will stipulate that Extra Care homecare must be delivered by the prime provider.

6.9 The new service will develop over time. Our ambition is to move towards a more **highly skilled workforce** delivering specified health and social care interventions, with appropriate governance and oversight. These interventions would be relatively low level, and will focus on those Long Term Conditions most prevalent among our homecare users and the main reasons they are being admitted after a visit to A&E.

6.10 Continuity of care should mean that homecare workers are constantly aware of the homecare user’s needs, and can identify when something has changed, when something is “not quite right” in their physical and mental health and escalate appropriately. Place based working will make the connections between homecare and the rest of the system stronger, facilitating this **escalation** process.

6.11 The new model is predicated on building **trust and partnership** between commissioners and providers. This means a much stronger role for providers in assessment and ongoing review and more freedom for providers to take

decisions with people who use homecare, without always needing to ask for permission. The new delivery model has a requirement for ongoing assessment woven throughout care delivery and the ability to flex, increase and decrease a package of care where necessary. This flexibility enables care to be focused and targeted as required.

7.0 Outcomes

7.1 Individual outcomes for people who use homecare will be agreed between the care provider and the care user (and their family/ carer/ advocate as appropriate). Over the course of the contract period we will work with providers to pilot and establish mechanisms for payment by outcomes.

7.2 The homecare programme will, as a whole, be expected to contribute to a number of outcomes and the providers will be asked to demonstrate how people, in receipt of the service have been supported to remain independent at home for as long as they are able to. This will be undertaken through robust contract management of the primary providers and MLCO.

7.3 We are also setting a number of service level outcomes, grouped below:

Home care population

- Improved overall satisfaction with home care services
- Reduction in avoidable use of acute services (as above)
- Reduction in number, and rise in average age, of admission to residential and nursing care
- Increased connection to community activities and reduced social isolation
- Improved quality of life

Carers

- Increase in the proportion of carers who report that they have been included or consulted in discussions about the person they care for (always, usually or sometimes felt involved)
- Reduction in carer breakdown

Homecare workers

- Improvements in satisfaction of workers
- Gaining qualifications
- Better career development pathways

Homecare providers

Improve the sustainability and quality of the homecare workforce, for example by:

- Increasing the number of apprentices
- Improving the qualification levels of staff (e.g. no. of staff with NVQ 2 & 3)

- Reducing staff turnover rates, particularly within the first six months of employment (either permanent or temporary)

Health and care system

- Reduction in avoidable use of acute services (as above)
- Reduction in number, and rise in average age, of admission to residential and nursing care
- Reduction in homecare hours

8.0 Personalisation and personal budgets

8.1 We are committed to commissioning services that deliver high quality personalised care services, where outcomes are achieved through the use of Personal Budgets (Individual Budgets & Personal Health Budgets). With the introduction of the Care Act in 2015 this approach was further reinforced, commissioners will work with the successful providers on how individual citizens can access care and support services in both Homecare and Extra Care settings using their cash individual budget, including through the use of prepaid cards.

8.2 A Personal Health Budget (PHB) is an amount of money to support an individual's identified healthcare and wellbeing needs, planned and agreed between the individual and/or brokerage service and the NHS. CHC recipients will have a 'right to have' a PHB, including direct payment. The use of personal health budgets is just one way in which the NHS can tailor services for people to enable them to have choice, control and flexibility over their care.

9.0 Finance and Cost Benefit Analysis

9.1 Across the MHCC Pooled Budget £16.5m is currently spent on homecare core (1,085,498 hours) with a further £1.9m on Extra Care (149,328 hours).

9.2 The latest financial modelling indicates that investment of £1.607m will be required in 2019/20 to deliver the new Homecare model, with a further investment of £343k in in 2020/21 and a further £253k in 2021/22.

9.3 Budget allocated for the national living wage increases will be used to meet £1.062m of the investment in 2019/20, rising to £1.395m in 2020/21. Further investment of £545k is required in 2019/20, it is being determined if this could be met from carry forward of projected underspend on the Adult Social Care grant in 2018/19. From 2020/21 an estimated £555k will need to be retained from savings to fund continuing investment into the model.

9.4 It is expected that over a three year period there will be savings made through bringing services into neighbourhoods, and no longer using the time and task model. The intent is to use part of the savings to re-invest into the model over time.

9.5 The new model of homecare is a strengths based model and we would expect the provider to work with us to improve the wellbeing of people and to reduce the hours of care for specific individuals. This is expected to deliver savings of £0.75m in year one which has been included in the approved budget for 2019/20 and a further £0.75m in 2020/21 of which £0.555m will need to be retained. The £0.75m saving each year is equivalent to 47,200 hours in 2019/20 or 4.3% of the budgeted hours.

9.6 There will also be a lower unit cost due to working in a neighbourhood and from improved retention of staff. Any further savings across Health and Social Care will be reviewed and captured as the scheme progresses, these will be reported in line with the evaluation process. However, as the MLCO matures along with MHCC joint commissioning intentions there is an acknowledgement that homecare is likely to increase as care moves from Acute setting to home based care.

10.0 Social value

10.1 Manchester's strong commitment to delivering social value through its procurement activity is reflected in the model for Our Manchester homecare. Many of the key features described above (investing in the workforce, local base and recruitment) are part of the overall ask of providers, rather than a separate social value 'ask'.

10.2 We will ask providers to demonstrate how they are already delivering social value and any additional measures they would implement as part of this contract. Some potential areas for realising additional social value through this contract are listed below:

- Environmental:
  -The neighbourhood model should decrease the amount of car travel necessary. Can visits be grouped to increase the number that can be carried out on foot, or by bicycle?
  - Can food choices and shopping support the local economy, reduce food miles and encourage new experiences through food?
  - Is recycling part of providers' business model and are there ways to increase recycling, reuse products or reduce single use products

- Economic:
  - Paying the Manchester Living Wage and ensuring this is promoted throughout the supply chain (including any subcontractors).
  - Recruitment practices which encourage people living in the communities where care is delivered to work as care workers, which gives a better cultural match, means people should have a good understanding of community and voluntary activity in the area, and reduces travelling.
  - Providing employment opportunities to people who have been unemployed for some time, particularly those in the city's priority groups.

- Social:
  - Connecting people using homecare to other services and people

- Using the knowledge and skills of local people, including homecare workers and homecare users to build connections and links in the local community
- Working with local voluntary sector organisations on joint projects

10.3 We have included some social value key performance indicators in the list of data we are expecting from providers.

11.0 Equality Analysis

11.1 We have completed an equality analysis on the proposed new model of homecare. Overall, the analysis found the new model would be likely to improve the service for groups with protected characteristics as it will be more personal, focussing on people's outcomes and goals rather than a set of generic tasks. Continuity of care will facilitate this personal, tailored approach. In addition, the requirement for providers to be based in local areas, recruiting local people means an increased likelihood that the service will respond to the diverse needs of Manchester residents.

11.2 The analysis did find a current issue in that most people using homecare are White or White British (80.0%) which is higher than the overall population (66.6%). The proportion of Asian / Asian British people using the service (9.4%) is lower than the overall population (17.1%) while the proportion of Black / Black British (8.1%) is similar to the overall population (8.6%).

11.3 As part of mobilisation work and ongoing service delivery, providers and Integrated Neighbourhood Teams will work together to identify individuals from under-represented groups eligible for homecare who would benefit from the service, focussing first on the lower than expected take up of homecare in the Asian/Asian British population.

11.4 The specification for the new service is clear that the city is ethnically diverse and is home to many communities of interest and identity and that in particular the city has a thriving LGBT community. This means that service providers must take account of our various communities when planning the provision of services, for example by recruiting staff from those communities and providing information to all staff on dietary, personal care and religious requirements.

11.5 The specification also signals that we are considering introducing an LGBT kitemark for care, which whilst particularly relevant in our forthcoming LGBT Extra Care scheme, is also relevant to the rest of homecare. Older LGBT people in the city have told us that they fear discrimination from care services.

12.0 Risks and dependencies

12.1 As highlighted above, the homecare market is fragile nationally and tender exercises inevitably bring some change and instability for a period. Much work has been done with providers over the past year to try to mitigate this risk, primarily the fee uplift described and also co-design and engagement work as part of the development of this service model. A provider event in July attracted around 70 attendees from 35 current, past and new providers.

12.2 The model described is predicated on interdependencies with a large number of other services and new care models which are also being developed. In particular, the success of Integrated Neighbourhood Teams is a critical factor in the success of the new homecare model. The successful implementation of the move to Liquidlogic will also have a significant impact, as will, over a longer period, the Manchester Care Record and an agreed model of Trusted Assessment.

12.3 Business cases for Assistive Technology, enhanced reablement and High Impact Primary Care assume that their successful implementation will lead to a reduction in homecare hours. Any issues for these projects will therefore have an impact on the new model of homecare.

12.4 Successful implementation of the new model will require ongoing work with providers and health and care services over a long period. We will need to work with MLCO colleagues to ensure this resource can be secured and maintained.

13.0 Next steps

13.1 The new model of homecare – Our Manchester homecare – will go out to tender later this month. Evaluation of the tender will be against a series of method statements and will involve users of homecare as full scoring members of the panel.

13.2 A detailed communications and engagement plan for the mobilisation of the contract is currently in draft. We are planning carefully how and when to communicate forthcoming changes to homecare users and others.

13.3 We are aiming to award the contract before the end of the calendar year before moving into an intensive period of contract mobilisation, with contract implementation starting from April 2019.

Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee- 4 September 2018

Subject: Manchester Public Health Annual Report 2018

Report of: Director of Population Health and Wellbeing/Director of Public Health

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Summary

As part of the statutory role of the Director of Public Health there is a requirement to produce an annual report on the health of the local population. This report can either be a broad overview of a wide range of public health programmes and activities or have a single issue focus. The 2018 report has a single issue focus on air quality.

Recommendations

The Committee is asked to note the report and comment on the recommendations listed in section 9 of the report.

Wards Affected: All

Contact Officers:

Name: David Regan
Position: Director of Public Health
Telephone: 0161 234 3981
Email: d.regan@manchester.gov.uk

Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

None

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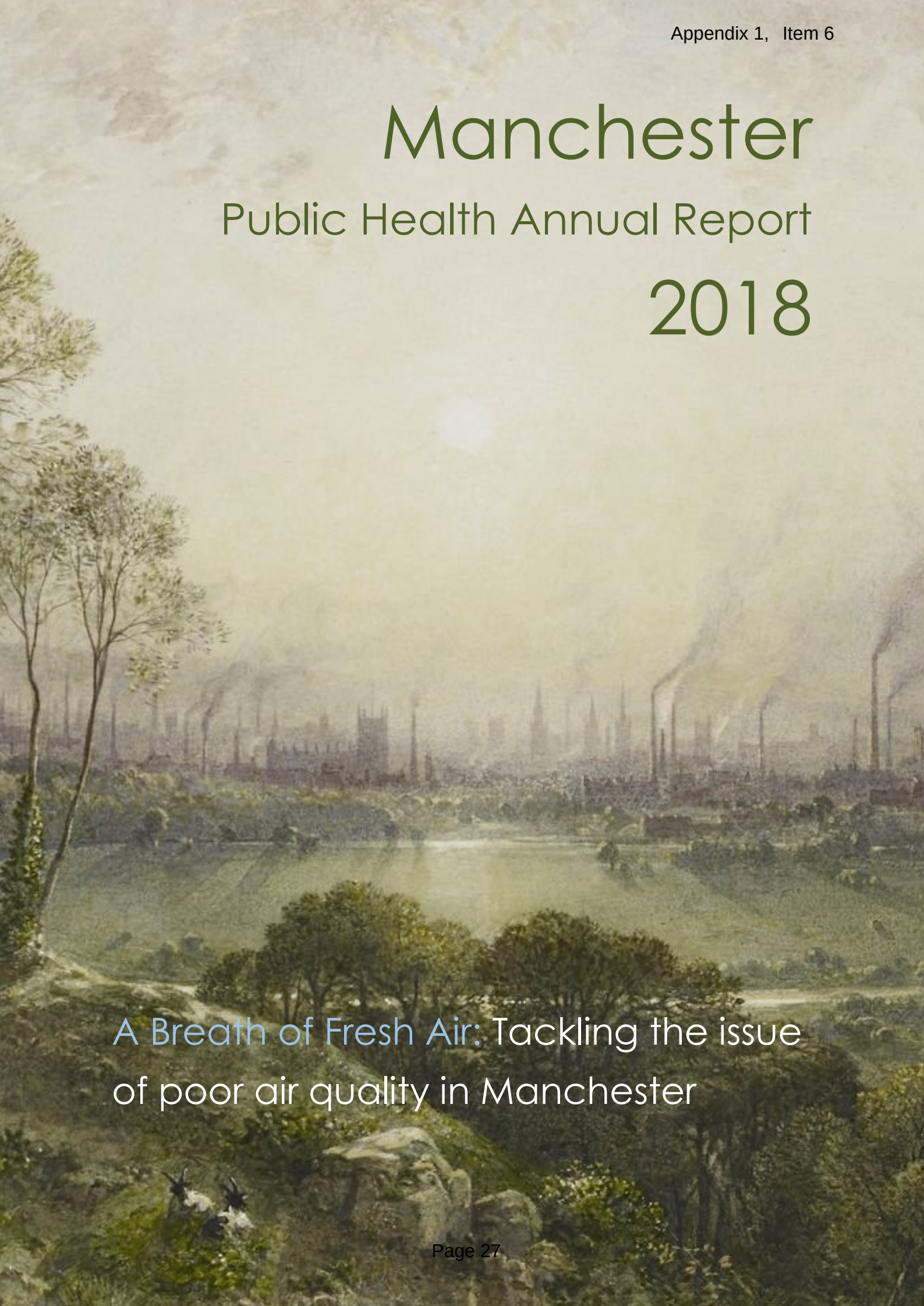
Manchester

Public Health Annual Report

2018



A Breath of Fresh Air: Tackling the issue of poor air quality in Manchester

Foreward

Councillor Bev Craig

Executive Member for Adult Health and Wellbeing

Air quality, or rather the lack of it, is a public health issue that has become increasingly prominent over the last few years.

This report is a timely summary of the effects that poor air quality has on both short term and long term health, and what this means for the residents of Manchester.

It's often easy to think of air quality as a national issue, or even an international one – after all, air pollution does not respect political or geographical boundaries. But this would be a mistake. The reality is that we are all partly responsible for air pollution, and can all contribute to making it better.

This report provides an overview of how we can all work together to improve the air that we breathe.

Councils in particular, with their roles in relation to transport, schools, and tobacco control are well placed to implement a variety of solutions with partners that can act to improve air quality. Manchester is already a part of the Greater Manchester Air Quality Action Plan, and is trialling a variety of innovative solutions.

There is cause to be optimistic. Recent measurements show that air quality in Manchester is improving, but there is still a lot of work to be done, and this report sets out some of the actions we can all take.

MANCHESTER CITY COUNCIL

Introduction

Poor air quality is an issue that Manchester has had to battle before, albeit in a different form. The front cover of this report shows William Wyld's painting of Manchester from Kersal Moor in 1853. It shows a smoky Manchester skyline dotted with the factories that helped power the industrial revolution, and made Manchester the city it is today.

But the painting also represents what the public perception of poor air quality often is; belching chimneys or city skylines blurred with the haze of traffic fumes; scenes more reminiscent in the public imagination of Beijing or downtown Los Angeles than of Manchester today. But while the smoking chimneys and furnaces in Wyld's painting have largely gone, the issue of poor air quality in Manchester has not.

And while the public have an increasing awareness of the detrimental impact of acute air pollution events such as smog, there is little comprehension of the *long-term* impacts of poor air-quality, the importance of indoor air quality, or even the fact that most of the time, polluted air looks and smells, just like air.

This is why this year I have decided to dedicate my annual report to this one issue. Raising local awareness of what modern air pollutants are, how they affect Manchester's population, and what we can do to reduce their production and people's exposure to them is crucial for local engagement to help both meet air quality targets, and to minimize their negative health effects.

I hope that you find this report informative. Only after learning about the risks of poor air quality can we truly start to address how to improve it.

David Regan

Director of Public Health,
Manchester City Council

Director of Population Health and Wellbeing,
Manchester Health and Care Commissioning (MHCC)

Manchester Health & Care Commissioning

CONTENTS

1. The air that I breathe... Why air pollution is important today.

The link between clean air and health is in some ways an instinctive and long-held one. We cough when we inhale irritants - and try to shield our mouths when exposed to smoky environments. In Victorian times fresh sea air was praised for its alleged restorative properties and offered respite from soot-filled cities. More recently the Great Smog of London in 1952 killed up to 12,000 people, harmed 100,000 more, and led to the implementation of the Clean Air Act in 1956 [1].

This link should not be a surprise; every day an average adult takes 20,000 breaths, and moves approximately 11,000 litres of air in and out of their lungs. Even low concentrations of pollutants can therefore have health impacts over time.

Figure 1: Volume equivalents of 11,000 litres of air. Comparisons are from http://www.bluebulbprojects.com/measureofthings

Today the smog and soot of the industrial revolution may have diminished, but they have been replaced with modern pollutants, such as nitric oxides and particulate matter (PM). These may be less visible, but epidemiological evidence on their impact on health is continually growing and evolving, revealing a multitude of effects that are both wide ranging and long lasting. Indeed, this evidence and an increasing number of acute air pollution episodes in several cities, has led Public Health England (PHE) to identify poor air quality as the largest environmental threat to public health in the UK, contributing to 40,000 premature deaths a year [2–4].

As well as the personal cost to health, the resultant problems can have impacts on hospital admissions [5], school attendance [6], and business productivity [7], meaning that poor air quality is also associated with substantial financial and societal costs.

Indeed, a recent report from PHE estimated that the total NHS and social care cost due to $PM_{2.5}$ and NO_2 was £42.9 million in 2017, and this could rise to £5.3 billion by 2035 [8].

Policies to improve air quality will have the potential to alleviate these costs, but they may also generate improvements to health via indirect means, such as through enabling exercise and physical activity, reducing injuries and accidents, and preventing social isolation.

Many people who live in poorer areas are often exposed to higher levels of air pollution [9], and may suffer a greater negative impact. Therefore policies to improve air quality will help Manchester reduce health inequalities within the city.

In addition, many of the things we can do to improve air quality will reduce other environmental pollutants, such as carbon dioxide, meaning that tackling air quality is a way of increasing sustainability and addressing the challenge of climate change [10].

Tackling poor air quality is therefore a way for Manchester to become a healthier place to live, work and visit as well as a fairer, greener, more productive city.

2. In the air tonight... What is air pollution and where does it come from?

Generally any chemical, droplet or particle in the air that is damaging to the health of people, animals or plants can be classified as a pollutant. These may be present outdoors or indoors. There are many air pollutants, but there are several of particular concern for Manchester:

Outdoor

Particulate matter (PM)

Particulate matter (PM) refers to a wide variety of liquids and solids that are suspended in the air and can carry toxic chemicals. PM is defined by its size. PM_{10} refers to particles that are less than 10 microns in diameter (approximately 5 times smaller than a human hair). $PM_{2.5}$ refers to particles at least four times smaller than this (Figure 2). These small sized particles can be inhaled into the deepest parts of the lungs, meaning they have the strongest link to poor health outcomes.

In cities, although vehicle exhausts, particularly diesel, are responsible for the majority of PM, significant amounts of PM are created by construction work, engine and break wear and domestic wood burners.

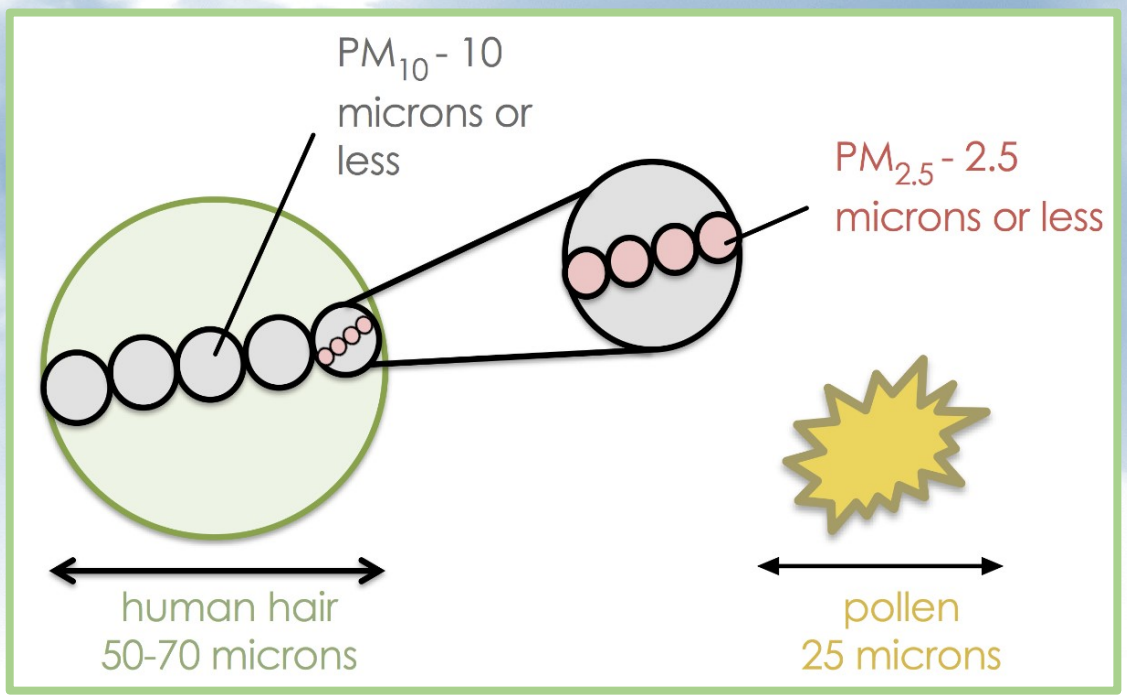


Figure 2: Particulate Matter (PM) Schematic representation of the scale of PM_{10} and $PM_{2.5}$.

Nitrogen Dioxide

Nitrogen dioxide (NO_2) is a gas that is often produced alongside nitric oxide (NO) by combustion processes. Together these are often referred to as oxides of nitrogen (NOx). NOx is an important air pollutant because it contributes to the formation of photochemical smog, which can have significant impacts on human health.

In Manchester and the UK in general, 80% of NOx emissions are due to vehicle emissions, particularly diesel light duty vehicles (cars and vans)[11]. Numbers of these vehicles have increased significantly over the last ten years[12]. Furthermore, the Volkswagen emission scandal has revealed that the emissions of many of these vehicles are higher than first thought.

Indoor

Whilst much attention has been directed towards poor air quality outdoors, we sometimes forget that we spend up to 90% of our time indoors. Consequently, keeping the air which we breathe at home clean is of necessary importance. There are a number of air pollutants that are associated with indoor space, including carbon monoxide, volatile organic solvents and aldehydes. These can be released from boilers or cleaning product[13]. However, one of the most important indoor air pollutants, and one that is particularly relevant for Manchester, is environmental tobacco smoke.

Environmental Tobacco Smoke (ETS)

Environmental tobacco smoke is smoke exhaled by smokers or given off by burning cigarettes, cigars, shisha pipes etc., which is then inhaled by others. The health effects of ETS (sometimes also called second hand smoke) are now well understood and are and legislation has been put in place to control exposure in public places[14,15]. However, we need to continue to educate people about controlling or reducing exposure to ETS in the domestic environment – particularly with regard to the exposure of children, and pregnant women and the unborn child.

3. Take my breath away…What are the effects on health?

Air pollution can cause a wide variety of health problems in people that are exposed to it. The risk of adverse effects depends on a number of factors, including current health status, pollutant type and concentration, and the length of exposure. Generally, the effects can be categorised as being either short term or long term.

Short-term health effects

In high concentrations both nitric dioxide (NO_2) and particulate matter (PM) can be a direct irritant to mucous membranes around the eyes, nose and airways, and can cause coughing, wheezing, dizziness and nausea[13,16].

Various studies have shown associations between poor air quality episodes and hospital admissions for asthma and chronic obstructive pulmonary disease (COPD).[17] Other studies have shown that NO_2 and PM can inhibit lung immunity, leading to increased susceptibility to infections, especially in children. Associations between poor air quality and illnesses such as pneumonia or bronchitis, and acute events such as heart attacks and strokes have also been observed[17].

Long-term health effects

The long term effects of air pollution accumulate throughout a person's lifetime, and can lead to a variety of health complications or even death[16]. In England, the Committee on the Medical Effects of Air Pollutants (COMEAP) estimated that NOx and $PM_{2.5}$ contribute to over 40,000 deaths per year[3,4]. Children are particularly vulnerable to the effects of ETS and exposure increases the risk of cot death, glue ear, asthma and other respiratory disorders, including emphysema later in life.

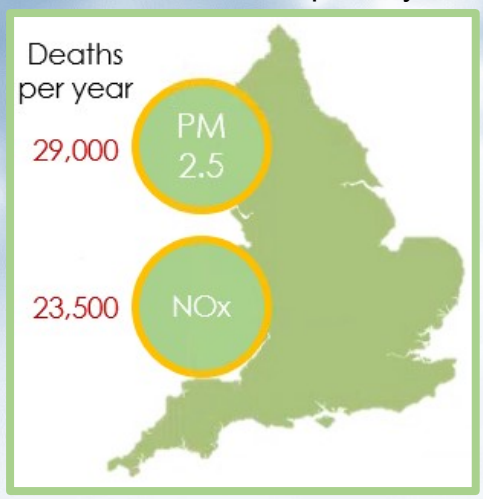


Figure 3: Estimated number of deaths caused by Oxides of Nitrogen (NOx) and Particulate Matter (PM) 2.5. Data are from COMEAP and are for England only. As there is overlap in deaths attributed to each the two pollutants, the deaths accorded to each do not sum, giving an estimated total of 40,000 deaths per year.

In addition to contributing to early death, evidence shows that long term exposure to air pollutants contributes significantly to morbidity, and can cause damage to people's immune systems, nerves, kidneys and other organs[13,17]. The International Agency for Research on Cancer (IARC – part of World Health Organization (WHO)), listed

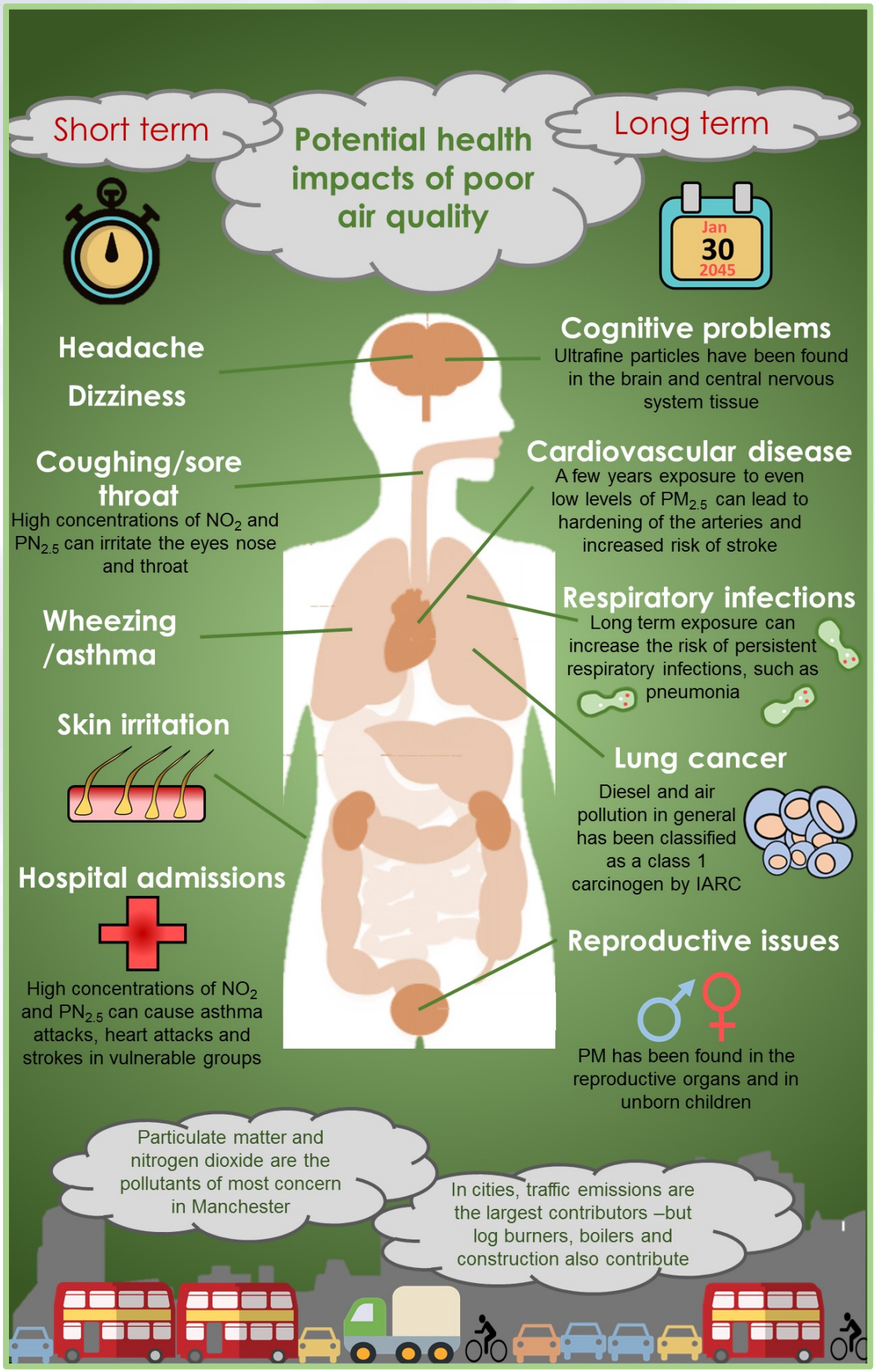


Figure 4: Potential health impacts of poor air quality.

diesel exhaust, and then air pollution generally, as a Group 1 carcinogen, and PM in particular has been associated with increased lung cancer risk[18,19]. Indeed, WHO estimates that poor air quality is a major contributor to some of the leading causes of death worldwide (20)(Figure 5). In addition, emerging evidence also suggests links with higher rates of still birth and the development of diabetes or obesity.

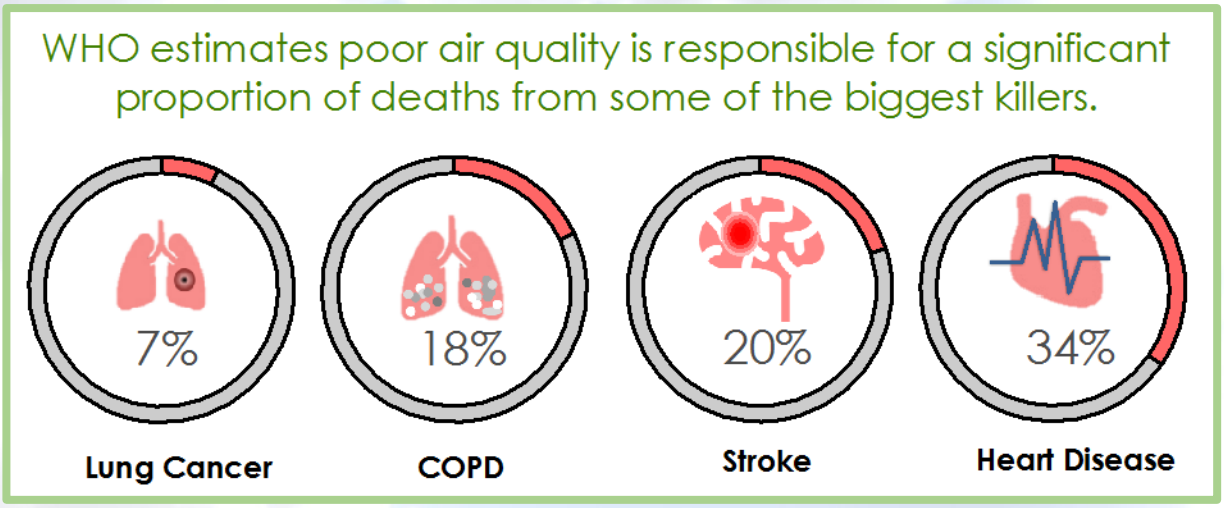


Figure 5: Estimated contribution of poor air quality to deaths from a number of conditions. Data are from WHO BreathLife 2030 website (http://breathelife2030.org)

Mental Health

The health impacts of poor air quality are not limited to physical health. Most people can relate to the happy feelings a warm summer day brings. It should therefore be no surprise that air pollution is a major influence of people's emotions and behaviours. Long-term exposure can result in a variety of psychological problems, such as depression, anxiety and irritability, which can have adverse effects on a wide range of behaviors such as exercising, commuting and socialising. Personal stories collected by the British Lung Foundation (BLF) show the effect that poor air quality can have:

"…air pollution has an effect on my life. It makes my condition so much worse."

"The depressing reality is that when we walk along busy roads to school, my children are breathing in dangerous levels of air pollution"

At risk groups

Air pollution can impact on everyone, but a number of groups are at greater risk. (Figure 6).

Children, from gestation, through infancy and later childhood are particularly vulnerable because of the rapid development of their bodies[13]. Furthermore, children take more breaths than adults, and tend to be more active, which can increase their exposure. As a result, children can be left with lifelong poor health attributable in part to outdoor and indoor pollution exposure.

Some older people can have weaker immune systems and therefore often have lower thresholds for poor air quality.

People who have pre-existing medical conditions, such as asthma, COPD, cardiovascular disease or diabetes are at greater risk. Exposure to air pollutants in these groups can increase the risk of asthma attacks, exacerbations, heart attacks, or strokes, increasing the need for medical attention or hospital admission[13,17]

People who work outdoors or people who exercise frequently outside may also have increased exposures.

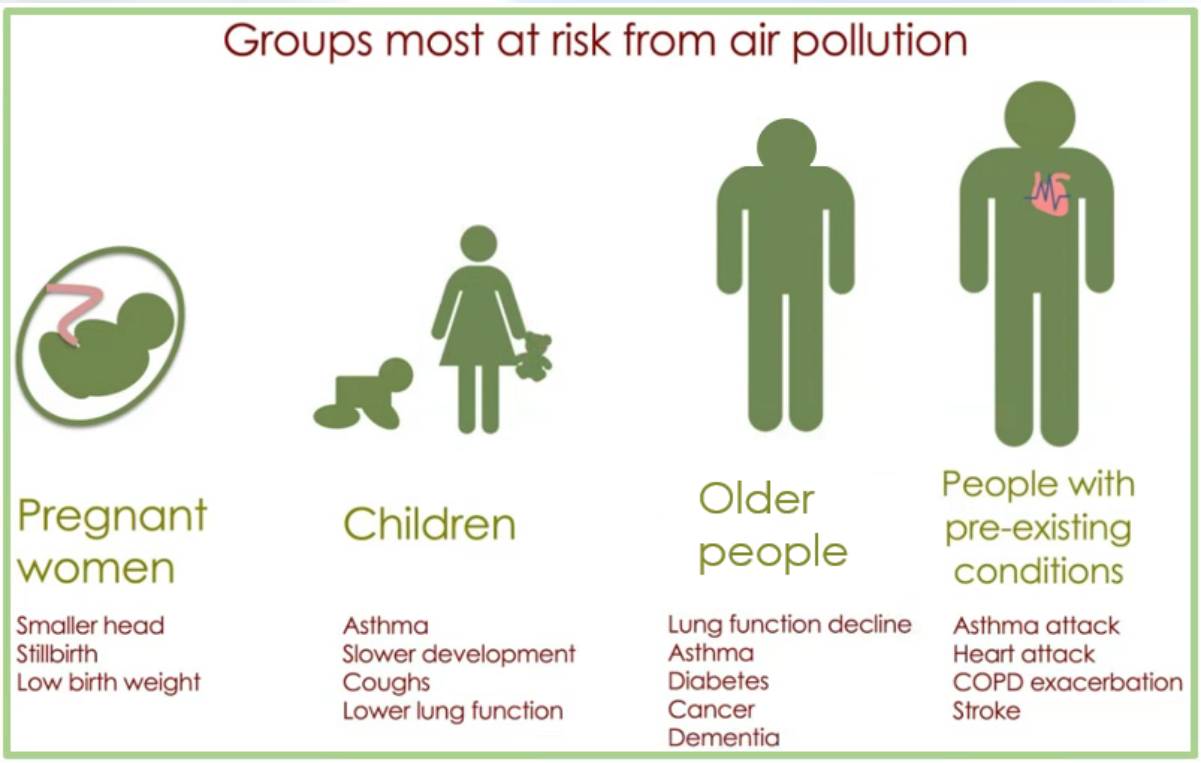


Figure 6: Groups at risk from poor air quality and some of the potential health effects.

4. Clean air is fair air… Inequality and air pollution

It is easy to believe that we all breathe the same air. However, the concentrations of the main air pollutants often diminish quickly as distance from their source increases. Although urban centres like Manchester have poorer air quality than rural locations due to traffic-related emissions, there is still significant local variation.

Studies analysing data at ward level have shown clear inequalities in air pollution[9], with the greatest exposure falling on communities who often live closest to the busiest roads. Furthermore, some of these same communities have the lowest levels of car ownership, meaning they are more adversely affected compared to more affluent suburban areas (Figure 7).

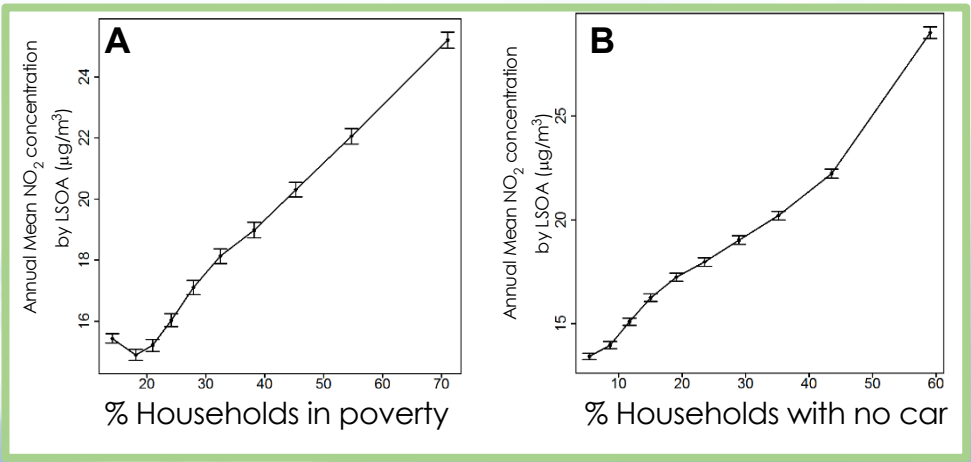


Figure 7: Air quality and deprivation. Relationship between average NO_2 levels and (A) poverty and (B) car ownership, at a lower super output area (LSOA) level. Data are from (9).

In addition to inequalities of exposure, people living in more deprived areas are more likely to have other health conditions as a result of their socio-economic position, which are further exacerbated by poor air quality. As a result, individuals in deprived areas experience more adverse health effects at the same level of exposure compared to those from less deprived areas[21].

This “double jeopardy” of increased exposure and susceptibility means that poor air quality undoubtedly contributes to health inequalities and will be particularly relevant for Manchester[22].

Detailed data are not available for the proportion of Manchester residents that live in deprived areas that are exposed to poor air quality, but there is a strong inequalities argument for tackling air quality. When the evidence clearly shows that it is the poorest and most vulnerable in our society that are suffering most from the effects of air pollution, the only fair air, is clean air.

5. Wind of change… European and national legislation

The health impacts of air pollution underpin European Union (EU) legislation (ambient air quality directive (2008/50/EC), which specifies the legally binding limits for concentrations in outdoor air of major air pollutants, including particulate matter (PM) and nitric dioxide (NO_2) (See table 1). These limits passed into English law through the Air Quality Standards Regulations 2010.

Compliance to these limits is mandatory. Breaches are likely to result in fines which a local authority will have to pay part or all of. Therefore the cost of interventions for improving air quality should be compared not to the *status quo*, but rather situations in which a local authority could be subjected to rolling fines of potentially unlimited amounts.

	Annual Mean	Other exceedance limits
Nitrogen Dioxide	40µg/m^3	1 hour average not to exceed 200µg/m^3 more than 18 times a year
PM 10	40µg/m^3	24 hour average not to exceed 50µg/m^3 more than 35 times a year
PM 2.5	25µg/m^3	N/A

Table 1: Pollutant legal limits (European Union 2016).

Given the health effects, health bodies and organisations needs to play a central role in ensuring health outcomes are appropriately considered in local action and across central Government policies. To this end, in June 2017, the National Institute for Health and Care Excellence (NICE) and Public Health England (PHE) published joint guidelines on outdoor air quality and health.

In addition, laws such as the Public Services Social Value Act 2012 mean that the NHS is under a legal obligation to consider the environmental harm for which it is responsible[24].

The Environment Act (1995)[25] requires local authorities to review air quality in their area to see if the above standards are being met. Breaches of the limits mean that an Air Quality Management Area (AQMA) should be declared and an Air Quality Action Plan (AQAP) produced, which sets out measures for achieving compliance.

In July 2017, the Department of the Environment and Rural Affairs (DEFRA) published its Air Quality Plan for tackling roadside nitrogen dioxide (NO_2) emissions[26]. This identified 38 'clean air zones', where NO_2 has been identified as a problem. Manchester (as part of the Greater Manchester urban area) was one of these zones, due to exceeding of the annual mean NO_2 limit value.

Greater Manchester based on current projections will not achieve compliance until at least 2020, therefore substantial action is required.

6. Every breath you take... Air quality and its health and economic impact in Manchester

There are a number of monitoring stations in Manchester, including sites at Piccadilly Gardens and Oxford Road. These show that like many major cities and urban centres, Manchester often suffers from poor air quality. Particulates and nitrogen dioxide levels are of the most concern from a health perspective.

Particulate Matter in Manchester

Particulate matter (both PM_{10} and $PM_{2.5}$) are within the legal limits for annual mean limits at both Oxford Road and Piccadilly Gardens (Figure 8). Likewise there have been no exceedances of the 1 hour limit for PM_{10} at either site in 2017 or 2018. Although this is reassuring, it is important not to be complacent. Levels have not dropped significantly over the last few years and it is worth noting that meeting these limits does not mean that there is no risk to health. WHO set no minimum threshold at which PM is thought to be safe[27].

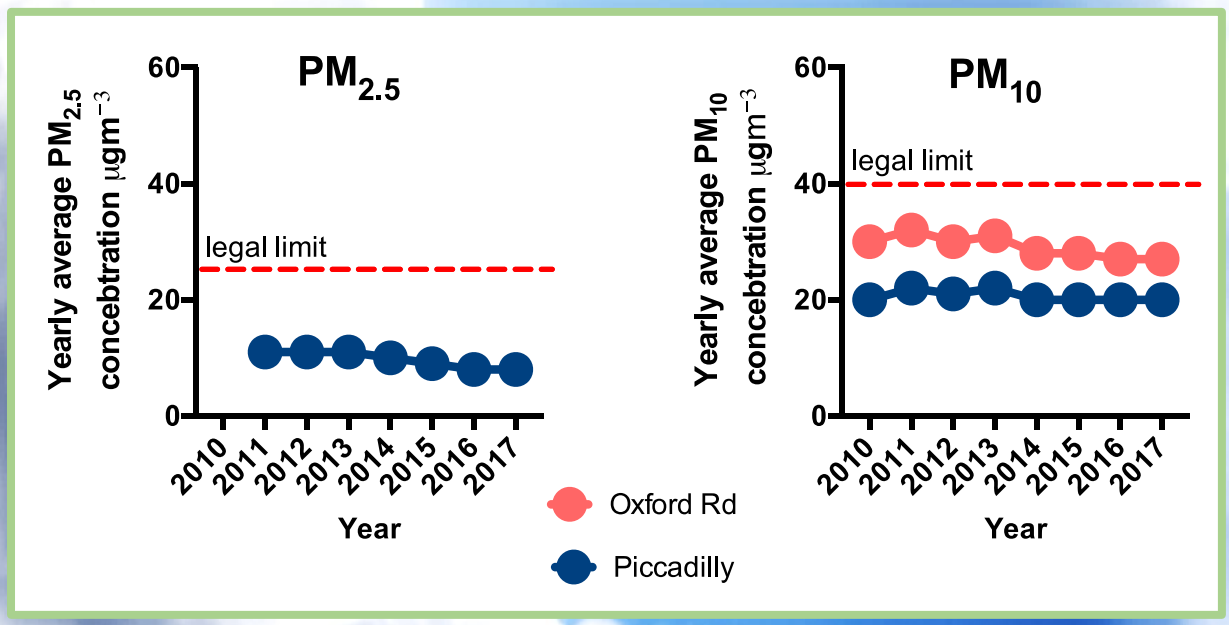


Figure 8: Recorded levels of particulate matter (PM) in Manchester. Data show annual mean levels of $PM_{2.5}$ or PM_{10}, measured at Manchester Piccadilly LA (MAN7) and Manchester Oxford Road (MAN1) sites, 2010-2017. Data are from Air Quality England. $PM_{2.5}$ data are not recorded at Oxford Rd.

Indeed, Public Health England (PHE) still estimated that the fraction of attributable mortality (see box 1) due to fine particulate matter ($PM_{2.5}$) in Manchester in 2016 was 5.2%. This corresponded to 180 deaths.

Manchester's fraction of attributable mortality is similar to that of England (5.3%) but is joint highest of all the North West Local Authorities (with Liverpool).

Box 1: Stat attack! What is attributable mortality?

Attributable mortality is the number of deaths that would be prevented in a population if the exposure (in this case air pollution) were removed. It can be represented as a number of deaths, or as a fraction (percentage) of total deaths in a particular demographic. It is useful as it gives a number that we can use to compare to other causes of mortality to assess the scale of the problem.

However, in this case the attributable number of deaths can be misleading as air pollution rarely kills people on its own. Rather, it makes existing illness worse. This means poor air quality shortens the life of many more people than the number of deaths in the attributable mortality statistic. Instead, for air quality, it can be more intuitive to think of attributable mortality as a number of deaths at a certain age that is *equivalent* to the estimated harm across a population.

Another way of expressing this would be to say that air pollution in Greater Manchester brings everybody's death forward by 6 months, or brings forward the death of someone with cardiovascular disease by 2 years.

The scale of the problem can be seen when this is represented as deaths per 100,000 persons and compared to other leading causes of premature mortality in Manchester (Figure 9).

Such comparisons show that the attributable death rate for particulate matter in Manchester is greater than the rates from a variety of other causes (such as drug related deaths and communicable disease) which have a much higher profile and dedicated resources to address them.

This figure is only the mortality associated with $PM_{2.5}$. It doesn't include other pollutants and therefore the overall impact of poor air quality on mortality is likely to be higher.

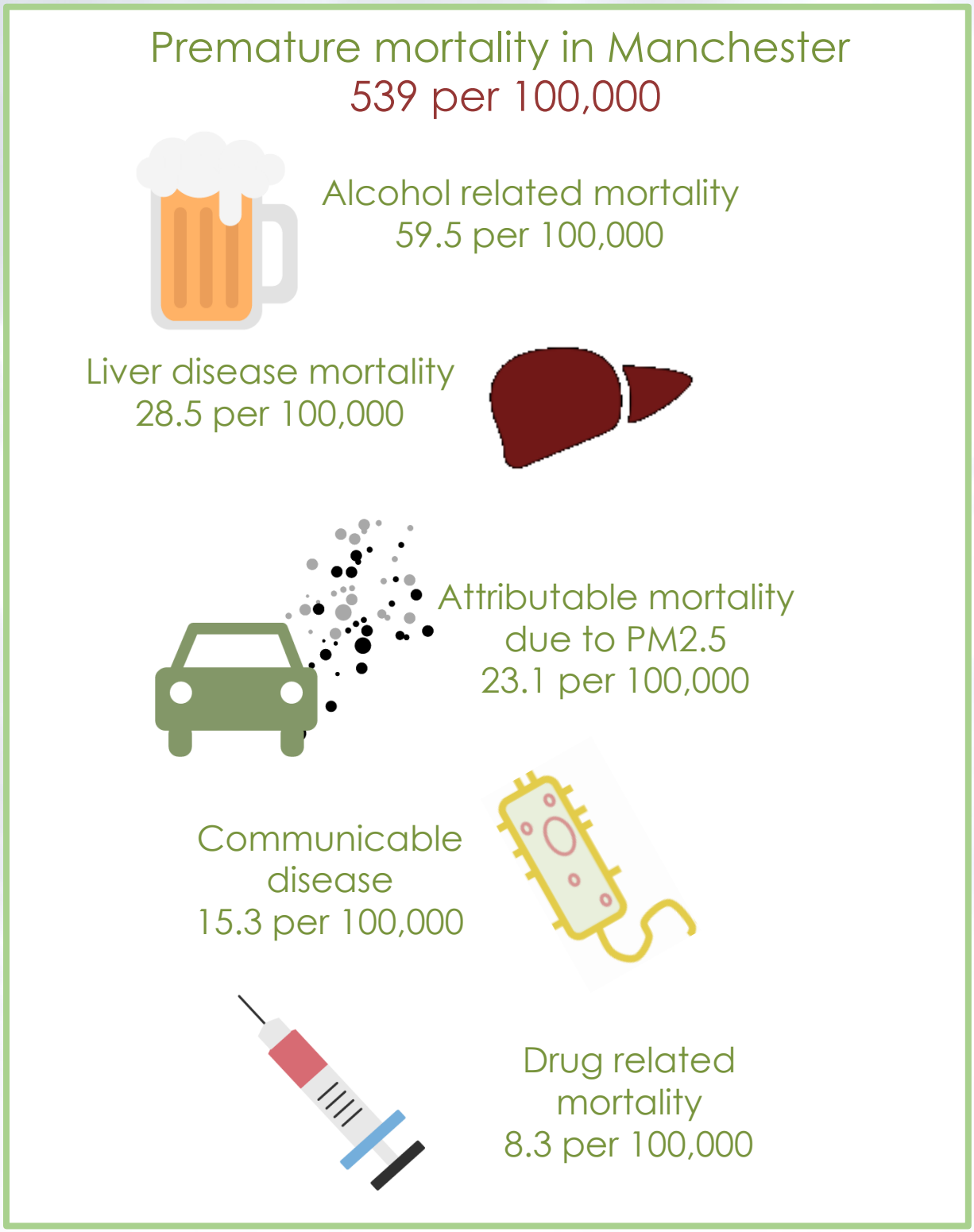


Figure 9: Comparison of causes of premature mortality in Manchester. Data obtained from Public Health Fingertips. Alcohol-related mortality is under 75 rate from 2016 (Indicator 4.01). Liver disease rate is for preventable disease, for under 75, 2014-16 (Indicator 4.06ii). Attributable mortality due to PM per 100,000 was calculated as in (16). Communicable disease is for 2014-16 (Indicator 4.08). Drug related mortality is for 2014-16 (Indicator 2.15iv).

Nitrogen Dioxide in Manchester

Like many other cities, another pollutant of concern for Manchester is nitrogen dioxide. This is actually the only air pollutant for which Manchester is breach of the legal limits. Modelling studies of NO_2 distribution show that it is associated with the arterial roads into Manchester and the city centre (Figure 10).

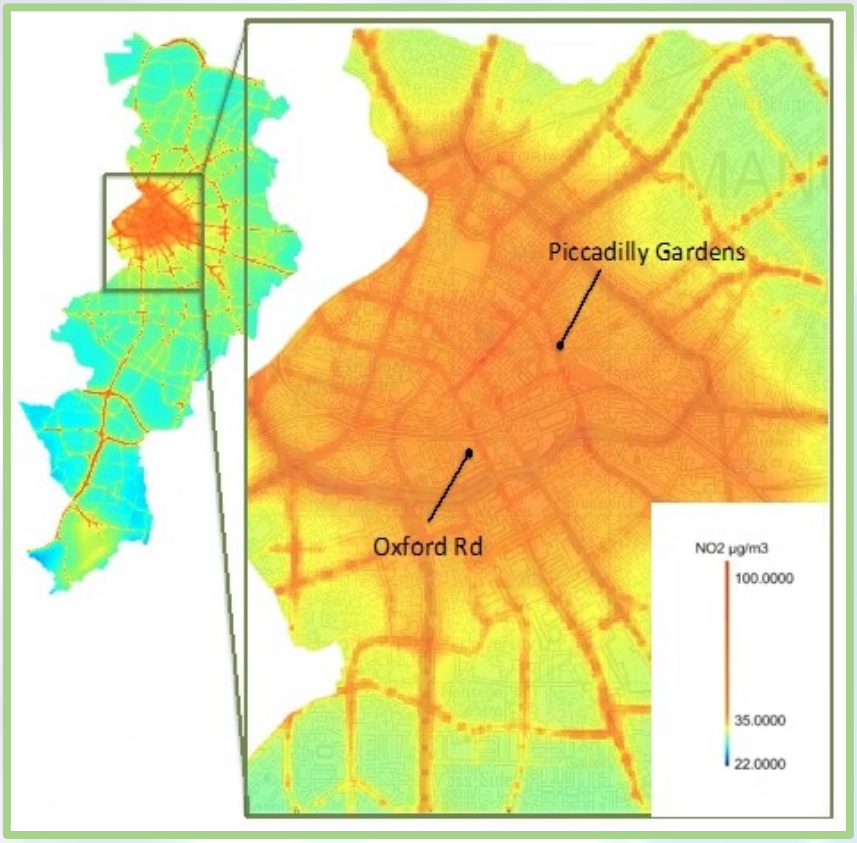


Figure 10: Map of yearly mean NO_2 levels in Manchester LA area and the city centre (enlarged section). Data are from models performed in 2016. Maps were produced by Transport for Greater Manchester (TfGM).

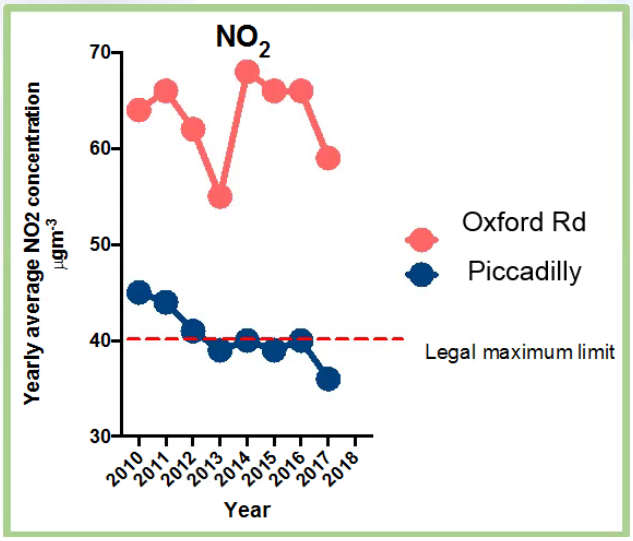


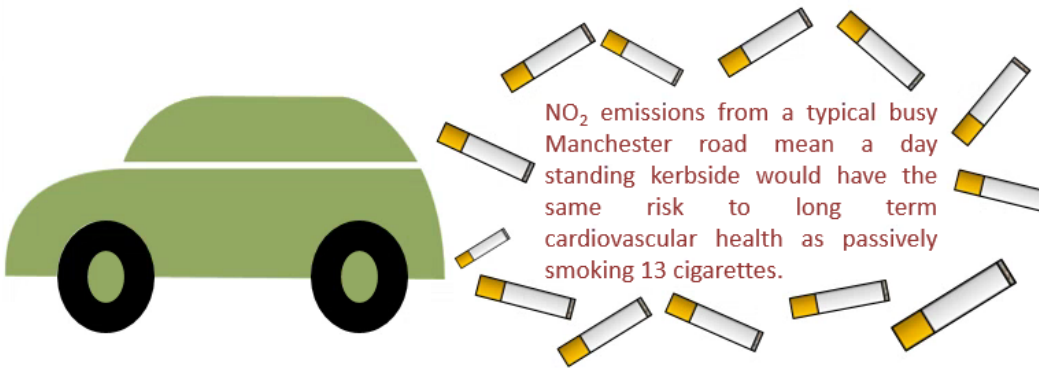
Figure 11: Recorded levels of NO_2 in Manchester. Data show annual mean levels of NO_2 at Manchester Piccadilly (MAN3) and Manchester Oxford Road (MAN1) sites, 2010-2017. Data are from Air Quality England.

Data show that recent concentrations of NO_2 have fallen in both Oxford Road and Manchester Piccadilly over recent years (Figure 11). This reduction has meant that last year, NO_2 levels at Piccadilly were within the legal limit. However, although NO_2 levels at Oxford Road have reduced by 15% between 2014 and 2017, the average mean concentration in 2017 was 59µg/m3, still 47% above the legal limit, and a level that has a potentially large health impact (Box 2). In addition, at the Oxford Road site the 200µg/m^3 24 hour limit was breached 90 times in 2016, but this dropped to 6 exceedances in 2017, and there have been none in the first half of 2018.

Box 2: Communicating the risk: Equating air pollution with smoking

Quite often the health risks associated with air pollution are poorly communicated with the public and policy makers. Terms such as attributable mortality are not well understood. In contrast, the risks associated with smoking are generally well known. For this reason, researchers in the Netherlands developed a method that expresses the health effects of air pollution as an equivalent number of daily passively smoked cigarettes[30].

Using this model and applying it to the yearly average NO_2 concentration at busy Manchester Roads illustrates the risks that poor air quality has to some of Manchester's population:



*For the calculation, background levels of NO_2 (obtained from DEFRA) have been subtracted from the recorded values to give an exposure that is due only to local emissions

Environmental Tobacco Smoke (ETS) in Manchester

Most deaths associated with ETS occur in non-smokers who live with a partner or family member who smokes. It is not possible to quantify the number of people in Manchester who are exposed to ETS but it is likely to be a substantial number given Manchester's high smoking prevalence; 21.7% of adults in Manchester smoke (rising to 27.6% for those in manual occupations), compared to 15.5% of adults in England. This is reflected by Manchester also having the highest number of smoking related deaths and second highest smoking attributable hospital admissions. In addition, in relation to pregnancy, 11.6% of mothers are still smoking at the time of delivery[28].

Manchester's vulnerable population

Manchester has a relatively young population compared with other cities in England but we know that health and care outcomes among our adult population are poorer than average and that people often have multiple health issues, and these are reflected in some of Manchester's health statistics:

- Manchester has the highest rate of childhood hospital admissions for asthma in England.
- Manchester has the highest under 75 mortality rate for respiratory disease in England.
- Manchester has the fourth highest rate of emergency COPD hospital admissions in England, over twice the national rate.
- Manchester has the highest under 75 mortality rate for cardiovascular disease in England.

It is likely that poor air quality contributes to all of these statistics – indeed there is now evidence that poor air quality is linked to asthma development as well as hospital admissions. Thus the number of people who are at increased risk from poor air quality in Manchester is substantial (Table 2). However, this also means that the benefits of improving air quality will also be substantial.

At risk group	Estimated Number of People
People aged over 65	50,244
Children under 5	46,556
Asthmatic (2016/17)	35,909
COPD (2016/17)	12,198
Coronary Heart Disease (2016/17)	15,006
Maternities (2016/17)	8,284
TOTAL	168,197

Table 2: At risk groups in Manchester. Age numbers are from Office of National Statistics mid-year population estimates 2016. Numbers of people with asthma, COPD or coronary heart disease are taken from GP quality outcomes framework (QOF) data and therefore may not represent prevalence in an epidemiological sense. Number of maternities is the denominator for the Public Health Fingertips breastfeeding initiation indicator (2.02i)

The economic cost to Manchester

Poor air quality does not only come with a cost to health; it is also associated with significant economic and financial costs, both to the healthcare system and the wider economy. A recent report from the Institute for Public Policy Research (IPPR) North showed that the economic cost of $PM_{2.5}$ to Manchester could be over £250 million per year[31]. This rises to over £1 billion per year over the GM area.

7. A breath of fresh air…What are we doing?

Better together – Actions at a Greater Manchester Level

Greater Manchester (GM) is the second most populous urban conurbation in the UK after the Greater London area. Actions taken to improve air quality at this level will have a far bigger impact than if Manchester acted in isolation.

The approved Greater Manchester Low Emissions Strategy/ Air Quality Action Plan (AQAP) was published in 2016[11]. It is structured around 3 broad themes: Reducing Traffic (by encouraging alternative travel modes); Increasing Efficiency (by making the most appropriate use of roads and vehicles for different tasks); and, Improving Vehicles (by encouraging less polluting vehicles to be used).

Although acting across the whole GM area, there have been a number of interventions that have impacted specifically in Manchester to improve air quality.

Going Dutch On Oxford Rd

Oxford Rd is a major arterial route into Manchester. A recent redevelopment was done to favour public transport and make it a lot more pedestrian and cycle friendly. As well as wider pavements, Dutch style cycle lanes have been installed which run either side of the road as well as behind each bus stop.

Transport for Greater Manchester (TfGM) have also worked with bus companies to improve the emission standards of vehicles using Oxford road.

Air quality along Oxford Rd has improved as a result.

There is now potential to extend the scheme though the ward of Chorlton.

Saying no to NO: Improving School Buses

Using monies from the Department for Transport Technology Fund, recently 41 diesel buses from TfGM's fleet of Yellow School buses were retro-fitted with cutting edge pollution control technology.

Tests showed the intervention reduced nitrogen oxides (NOX) emissions by 99%, delivering significant environmental benefits and reducing children's exposure to harmful air pollutants.

It was so successful it won a National Clean Air Award for Local Authority Air Quality Initiative of the year!

The Mayor of Greater Manchester has recently made sustainability and air quality a leading priority for the region. Alongside other initiatives, the idea of a Clean Air Zone (CAZ) is being considered.

Local actions

As well as the initiatives that are taking place at a GM level, Manchester is also taking action at a city level. The actions fit well with the principles of the Our Manchester strategy (2016-25), which includes strong commitments to improve air quality and achieve environmental sustainability.

The City Council has established an Air Quality Steering Group with representation from Manchester Health and Care Commissioning, including the Population Health and Wellbeing Team. The Air Quality Steering Group are currently coordinating work to identify Manchester schools within the Air Quality Management Area and explore mitigation measures, including green screening, to reduce exposure to pollutants.

Actions to address climate change also help to address air quality. The City Council is a partner in the "Manchester: A certain future" strategy, which aims to reduce CO_2 levels by 41% by 2020, and for Manchester to become carbon neutral by 2050. Similarly the Council's 'Green and Blue Infrastructure Strategy' will help improve air quality while allowing residents to make the most of Manchester's parks, river valleys and canals.

Action is also being taken at a community level. By taking a local perspective and linking air pollution to specific locations such as busy roads, junctions or schools, then it becomes possible to discuss interventions to improve air quality at these locations. This helps shift the view that air pollution is something that can only be solved with larger systemic changes and allows residents, local councillors and others to take more ownership of the issue. Such an approach has successfully been used in Hulme, which has identified air pollution as an issue of local importance, and have launched its own action plan on how to help improve air quality (Case study 1).

This type of approach has two main advantages. Firstly, residents are more likely to be engaged and thus change their behavior if they have been part of decisions made about interventions. Secondly, communities that better understand air pollution can often become powerful advocates for action and improvement in their local area.

Case Study 1: Nature of Hulme

Situated just South of the city centre, Hulme has a population of approximately 20,000 people. Bordered to the North by Stretford Rd and to the East by Princess Rd, and in close proximity to Mancunian Way, parts of Hulme lie in Manchester's Air Quality Management Area (AQMA). Therefore improving air quality is an agreed local priority.

Hulme has a history of environmental activity led by residents, Councillors who support and lead environmental improvement through community based approaches and organisations who want to support this way of working.

In 2017, the Hulme Neighbourhood Team in Manchester City Council commissioned West Country Rivers Trust to start a programme called Nature of Hulme.

The programme has two strands of activity:

1. To map and analyse green spaces, existing environmental issues and recent environmental research in Hulme and develop a toolkit which demonstrates the impact of interventions.

2. To run a series of community engagement activities with people who live, work, study and play in Hulme. This was to gain their perspective of the environment and how it could be improved. This was carried out through community workshops, drop in sessions, and work in schools and online surveys

From this, a vision to improve the Nature of Hulme for this generation and beyond is currently being developed. This vision will inform an annual action plan made up of collective and individual actions. Some of the actions will be quick while others will take longer to reach fruition.

Through the community engagement and mapping work, air quality issues were identified, alongside other issues that contribute to air quality problems (such as school drop offs and lack of cycling infrastructure).

A number of activities that people, groups and organisations are interested in doing, or have already started, include:

1. Road safety drama workshops followed up by enforcement and information days, to encourage parents to try alternative transport options for school pick up and drop off.

2. Citizen science activity, for example installing air quality tubes, which act as a catalyst for community activity for improving air quality (for example, tree planting).

3. Wildflower, tree planting, street planters and green bus shelters.

4. School-based environmental work with students such as anti-idling, planting and greening achieved through the application of Neighbourhood Investment Fund (NIF) grants alongside environmental awareness work.

5. Community wardens, where residents lead their own environmental and street improvements.

6. Improvements to pedestrian routes and road crossings to create safe walking routes.

7. Strengthen connections between Manchester City Council, the Universities, developers and residents to collaboratively work to find achievable solutions to issues and develop sustainable future plans

Recently the report of the Chief Medical Officer[29] emphasized the important contribution that the health system itself can make in improving air quality. The NHS (both practically and symbolically) has a special role in not only curing disease but also in prevention. This can extend to the NHS's environmental footprint and in particular its impact on air quality. The NHS is now responsible for almost one in 20 of all vehicles on the road, made up of patient and staff travel and its own fleet of vehicles. This will be reduced if staff can be incentivised to travel to work differently, if the right care is provided in the right place, and by implementing models of care that involve the least amount of travel. All these things are now happening in Manchester (case study 2).

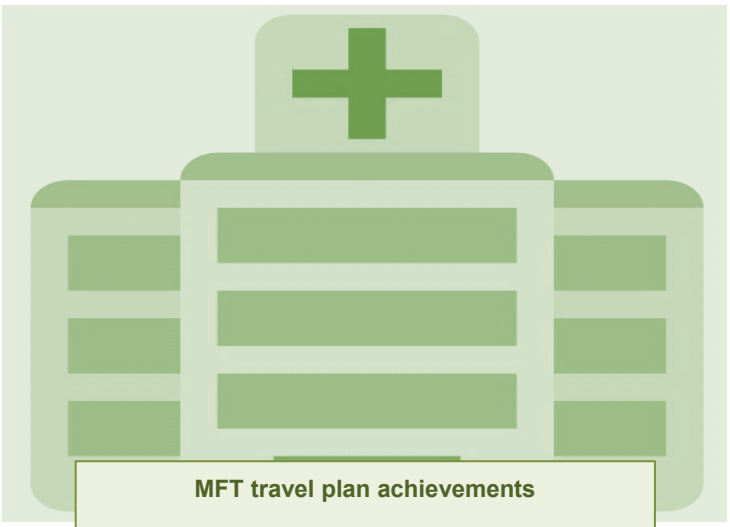
Manchester's new Prevention Programme aims to take a person and community-centred, asset-based, approach to delivering care and improving health outcomes for residents in the twelve Manchester neighbourhoods.

Neighbourhood Health and Wellbeing Development programmes and local Health Development Coordinators will enable residents to identify and address the issues impacting on their health and wellbeing, including air pollution. The programme will also provide a key opportunity for public engagement and education around the issue of air quality using an 'every contact counts' philosophy. The services will work closely with other wellbeing services in the city such as Buzz, and the Be Well social prescribing service to support individuals to change lifestyles and behaviours, including physical activity and smoking cessation.

In tackling indoor pollution, the development of the Manchester Tobacco Control Plan provides an opportunity for a range of different agencies across the city to work together to address the health impacts of Environmental Tobacco Smoke. This includes supporting the work on smoke-free policies across Greater Manchester, rolling out smoke free outdoor spaces, smoke free homes, and continuing to work with the trading standards and public protection teams at the City Council. This helps to ensure that any breaches or misunderstandings about the application of the Health Act 2006 are dealt with on an ongoing basis and that all tobacco-related legislation is enforced. Indeed, the Manchester Population Health and Wellbeing team, working with other colleagues at the council, recently ran a successful intervention that targeted Shisha cafes in the city (case study 3).

Case study 2: Leading by example – How health services in Manchester can make a difference.

In Manchester, the new One Team Prevention Programme will put in place infrastructure that will allow patients to access care locally. Although the primary aim is to support sustainable, coherent and effective community based approaches to prevention across the city, a secondary effect will be a reduction in the amount of journeys patients will have to make, which will contribute to emission reductions across the city.



MFT travel plan achievements

- 4.3% decrease in single-occupancy car travel
- 0.7% increase in bus travel
- 5% increase in active travel

It's not just patient care that can make a difference. Various health organisations in Manchester employ thousands of people. Manchester University NHS Foundation Trust (MFT) introduced a travel plan in 2015. This included initiatives such as travel discounts (for First and Stagecoach buses), interest free loans and improving cycling facilities. With the three Manchester CCGs recently joining together with Manchester City Council to form Manchester Health and Care Commissioning (MHCC), there is a great opportunity to build on this and promote a scheme across the city.

Case study 3: Tackling Shisha in Manchester

Some areas of the city have a high number of Shisha (or Hookah as it is commonly known) bars. These are legal but are bound by the 2007 smoking ban and can only operate in areas with three sides open for ventilation.

Nonetheless, the risks of inhaling shisha smoke, either directly or passively are much higher than people think. The filtration through the water doesn't filter out the harmful tobacco smoke and the exotic flavours mask the tobacco taste and make it easier to smoke shisha for longer periods at a time.

In fact, an average shisha session can last about one hour and can be as damaging to health as smoking 100 cigarettes. It also produces high levels of environmental tobacco smoke that negatively impacts air quality.

Manchester City Council launched a campaign to raise awareness of the dangers and legality of smoking shisha to tackle these common misconceptions surrounding it.

Population health postcards warning of the health risks as well as the legality of smoking shisha were distributed to all the cafes and their customers.

A multi-agency team, led by Manchester City Council's Licensing and Out of Hours Compliance Team, visited shisha cafes to deliver this health message and to ensure that cafes and customers were complying with the legislation.

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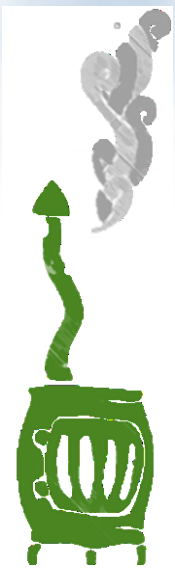
8. Making a difference…What can we all do?

It may feel as though air quality is too big an issue to tackle on an individual scale. However there are many things we can all do that can reduce the amount of air pollution we generate or are exposed to. Small actions all add up and can make a real difference over time.

Reducing our emissions

Drive less – The best thing we can do, where we are able to, is reduce our reliance on cars. The best choice would be to walk or cycle so we get the benefits of exercise, but using public transport such as buses or the Metrolink can also contribute to emission reductions. If we need to drive, then we should try and time our journey to avoid peak times – congestion significantly increases the total amount of emissions.

Don't idle. Idling a car for 10 minutes uses the same amount of fuel as driving for a mile – but the emissions all end up in the same place. The effect is made worse if multiple vehicles are idling at the same time. This occurs at taxi ranks or at the school gates. The latter is of particular concern because we know that children are particularly susceptible to the effects of air pollution. Cutting idling could reduce emissions by as much as 20-30% in the worst affected areas.



Make sure tyre pressures are correct. Tyres only 15psi (1 bar) away from the correct pressure can increase fuel consumption by 6%, with a subsequent increase in emissions. Checking tyre pressure regularly will help cut emissions, and will also save you money.

Reduce the use of wood and coal - or switch to a cleaner burning modern wood stove, and burning quality wood or smokeless fuels on open fires instead of wet/green wood or house coal will reduce emissions and exposure to particulate matter.

Reducing our exposure

Drive less. Exposure to air pollution inside vehicles can be as high as or higher than outside, particularly if sat in traffic. Thus, if we are able to do so, choosing an alternative to the car reduces our exposure, as well as our emissions. If we need to drive, put the car's air conditioning system onto recycle when sat in traffic.

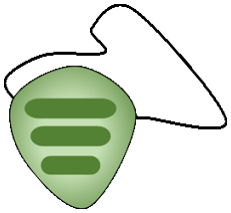
Try and choose routes that avoid the busiest roads - Pollution levels can fall by a factor of 10 just by moving a few metres away from the main source of the pollution. Even walking on the side of the pavement furthest away from the road or standing back from the kerb when waiting for the lights to change can reduce our exposure. When using the bus, research shows that sitting on the opposite side to the driver (or upstairs on a double decker) can decrease our exposure by 10%.

Be aware of local air quality -Vulnerable individuals can also take steps to be aware of air quality episodes and manage symptoms in consultation with their GP.

Don't forget indoors - We need to protect ourselves indoors too. Opening windows or smoking outside can help reduce exposure to environmental tobacco smoke.

Myth busting!

I'd better not walk or go outside then! Although it is a major public health threat, air pollution can't be viewed in isolation to other public health issues. The health impacts of sedentary lifestyles and obesity are also great. The benefits of active travel and exercise are far larger than the risks from air pollution for most people, most of the time. People should walk and cycle when they are able to, and children can play outside.



Should I wear a mask? The evidence for the effectiveness of masks is mixed. Some expensive ones with activated charcoal can filter NO_2, but even these can't filter out ultrafine particulate matter. Even if there is a small gap around the mouth, any benefit gained will likely be lost.

Poor air quality is a price we need to pay for economic growth. Studies have shown that poor air quality has an economic cost. Tackling air pollution can be a key element of growth and regeneration policies, and city centres can benefit in many different ways from measures that reduce air pollution and increase their appeal as places to visit or do business.

9. Recommendations and conclusion

Recommendations

In this report we have seen how the quality of Manchester's air has a number of short and long term health effects that also come with financial and economic cost. Furthermore, it is the poorest and most vulnerable, including our children that shoulder the greatest burden.

Based on this report I have listed below a series of recommendations to be considered over the next year that will contribute to our ongoing efforts to reduce the negative impacts of poor air quality on health.

We call on:

1. Health and social care partners to further develop and implement policies for Active Travel to enable shifts to healthier modes of travel for staff, patients and users of services.

2. NHS organisations working with Public Health England to actively promote clean air campaigns and positive public health messages on cycling and walking.

3. Wellbeing services in Manchester to incorporate key messages on reducing air pollution into 'making every contact count' when providing 1 to 1 lifestyle advice to residents.

4. Systems to be developed to help GPs and primary care staff provide bespoke advice to patients with Chronic Obstructive Pulmonary Disease (COPD) and asthma on how to manage their conditions when air quality is poor (e.g. text alerts).

5. The Manchester Healthy Schools Programme and the School Health Service to work with schools on education programmes that raise awareness about the risks of poor air quality and how to reduce the negative health impacts on children and young people.

6. The City Council to lead work in taking forward recommendations from Greater Manchester Making Smoking History Programme in relation to smoke free spaces, which has the support of 80% of residents across Greater Manchester.

Conclusion

For too long, the relationship between economics and environmental issues has been seen as a zero-sum game; for the environment to win, the economy must lose. This should not be the case, and indeed is not the case. Notwithstanding the legal, moral and even the health arguments for taking action, it has become clear that sustainable development is the only form of development that makes sense.

Wyld's picture was painted at the end of the industrial revolution. It was a time of great technological advancement, which brought not just social change but also opportunity – an opportunity that Manchester grasped.

165 years after Wyld's picture, we stand on the verge of another revolution. This time not an industrial one, but a green one - powered not by coal and steam, but by information and technology. Manchester again has an opportunity; we have never had more awareness of how our actions and policies impact on the health of both ourselves and our planet. If we choose to, we can make Manchester a city of clean skies and green spaces - a world leader in sustainability and regeneration. We have the knowledge, technology and talent – it is just a question of willpower.

Manchester's residents and policy makers need to be informed so they can reduce their own pollution footprint and more importantly, advocate for bold pollution-beating interventions. I hope that this report can be a small step in this process. By working together, we can beat poor air quality and build a Manchester that future generations can be proud of - a Manchester with clean air that is healthy and prosperous for all.

10. So you want to know more?....

There is a wealth of information that is now available on the topic of air quality, its impacts on health, and the best ways to beat it. It's not been possible to fit it all in this report. Here's some other sources of information that you may find useful:

- In 2016 the Royal College of Physicians published a report "Every breath we take: the lifelong impact of air pollution". It gives a comprehensive overview of the scale and breadth of the harm to health caused by air pollution, including indoor air pollution. https://www.rcplondon.ac.uk/projects/outputs/every-breath-we-take-lifelong-impact-air-pollution

- WHO's Breathlife 2030 website features a range of information on air quality, including resources for individuals, health professionals and cities. http://breathelife2030.org/

- The Chief Medical Officers (CMO's) 2017 report focused on the health effects of pollution in general, but contained sections on air quality. It made a series of recommendations on how air pollution can be reduced. https://www.gov.uk/government/publications/chief-medical-officer-annual-report-2017-health-impacts-of-all-pollution-what-do-we-know

- The Greater Manchester Air Quality Action Plan details the actions that are being taken at a local level to improve air quality. https://www.greatermanchester-ca.gov.uk/downloads/download/78/gm_air_quality_action_plan_2016-21

- Manchester City Council has a Joint Strategic Needs Assessment (JSNA) topic paper on air quality. This outlines the health impact in Manchester and details local policies and strategies, including the role of the population health team. http://www.manchester.gov.uk/downloads/download/6808/adults_and_older_peoples_jsna_-_air_quality

- You can keep up to date about the air quality in your area by using the UK AIR website, which hosted by the Department for the Environment and Rural Affairs (DEFRA). https://uk-air.defra.gov.uk/

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Acknowledgements

I would like to thank Dr Martin Bewley, Speciality Registrar in Public Health, for his outstanding work in co-ordinating the production of this report, supported by Barbara Drummond, Programme Manager with the Population Health and Wellbeing Team. Thanks also to Ian Hull, at Transport for Greater Manchester for the generation of maps.

Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee – 4 September 2018

Subject: LGA Adult Social Care Green Paper: Draft Manchester input

Report of: Executive Director of Strategic Commissioning and Director of Adult Social Care

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Summary

This paper is Manchester's draft input to the LGA green paper on adult social care and wellbeing, The lives we want to lead. The period for consultation ends on 26 September 2018.

The LGA's paper is particularly welcome given the time it has taken for the Government to release its own green paper on adult social care. The LGA work should be a helpful catalyst for Government to focus urgently on the future funding of social care, starting by recognising that significant, sustained additional funding is required. This must be in the broader context of the continued uncertainty and significant underfunding for local government.

The LGA paper starts from the national funding gap. It calculates that since 2010, councils have had to bridge a £6 billion funding shortfall just to keep the adult social care system going. In addition, the LGA estimates that adult social care services face a £3.5 billion funding gap by 2025, just to maintain existing standards of care.

This paper sets out the context in Manchester, including the significant challenges on adult social care in terms of finances, demographics, and increases in demand.

Devolution to Greater Manchester has allowed Manchester to be more ambitious about how to integrate social care and health. The locality plan, 'Our Healthier Manchester', sets out how this will fundamentally improve the health outcomes of our population, and achieve financial and clinical sustainability. Properly funded, sustainable adult social care is fundamental to delivering our ambitions and plans. Certainty is needed that sufficient funding will be available to meet continued increases in demand and cost, and to invest in new ways of working and transformation.

The LGA have developed a series of funding options to propose to Government. Of the options presented, the suggested preference is raising additional funding through national taxation. These options are on the right scale financially. These options also enable a progressive approach to raising funding from those who are most able to pay, with the funding to be distributed effectively to local authorities, properly recognising where it is most needed including demographic factors, health outcomes, and levels of deprivation.

Recommendations

Committee are asked to comment on the draft Manchester input to the LGA Adult Social Care Green Paper

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Wards Affected: All

Alignment to the Our Manchester Strategy Outcomes (if applicable)

Manchester Strategy outcomes	Summary of how this report aligns to the OMS
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	Adult social care is an important source of employment in the city. The future funding of adult social care directly influences the level and type of employment opportunities available.
A highly skilled city: world class and home grown talent sustaining the city's economic success	Adult social care is a significant sector of employment for Manchester residents, and this paper calls for significant additional future funding in order that we can effectively resource the sector.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Adult social care is a key part of the Our Healthier Manchester Locality Plan for health and social care, which sets out our ambitions and approach to improving health and wellbeing in the city.
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

Contact Officers:

Name: Dr Carolyn Kus
Position: Executive Director of Strategic Commissioning and Director of Adult Social Care
Telephone: 07976 792096
E-mail: carolyn.kus@manchester.gov.uk

Name: Carol Culley
Position: City Treasurer
Telephone:0161 234 1070
E-mail: r.rosewell@manchester.gov.uk

Name: James Binks
Position: Head of Reform and Innovation
Telephone: 0161 234 1146
E-mail: j.binks@manchester.gov.uk

Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

None

LGA green paper for Adult Social Care and wellbeing
Draft Manchester input

1 Introduction – the need to act

1.1 Manchester welcomes the opportunity to input to the LGA's green paper on the future of adult social care and wellbeing, *The lives we want to lead*.

1.2 The LGA's paper is particularly welcome given the time it has taken for the Government to release its own green paper on adult social care. This work should be a helpful catalyst for Government to focus urgently on the future funding of social care, starting with the recognition that significant, sustained additional funding is required.

1.3 This must be in the broader context of the continued uncertainty and significant underfunding for local government. If the broader issue is not addressed, more councils will cut other services in order to balance budgets, which will in turn impact on economic growth, well-being, and the wider determinants of health. The current financial situation in some local authorities brings into sharp relief the risks associated with further delays on both of these matters.

1.4 Of particular concern is the future of the Improved Better Care Fund which equates to £28.1m in 2019/20. This, coupled with the Spending Review, the fair funding reforms and business rates reset and system changes, all significantly hinder effective long term planning in local government, and with our partners in health.

2 Manchester context – we need to meet the challenges of rising demand and cost, within the unique opportunity of devolution

2.1 Manchester is proud to have taken a lead on devolution with Government over the last five years, including the ground-breaking arrangements on health and social care devolution. The Greater Manchester *'Taking charge'* strategy is now being implemented across the conurbation. The strategy sets a clear direction for reform across a population of 2.8 million people with some of the poorest health outcomes in the country and very significant financial challenges. It starts from the principle that integration of health and care is best led locally, by the key partners in each of the 10 local authority areas in Greater Manchester, working differently with each other, with national Government, and with people in places.

2.2 Devolution to Greater Manchester has in turn allowed Manchester partners to be more ambitious about how to integrate social care and health across the city. The locality plan, *'Our Healthier Manchester'*, sets out how this will fundamentally improve the health outcomes of our population, and achieve financial and clinical sustainability. Some of the health and social care challenges faced are:

<u>Financial pressures</u>

- £147 million system-wide financial gap for health and social care in Manchester by 2020/21. Greater Manchester estimated the health and social care financial gap to be around £2 billion between 2015 and 2021. The LGA

have calculated the national gap to be £3.5 billion by 2025 just to maintain current standards of care.

- Adult Social Care has increased as a share of the MCCnet budget from 29% in 2010/11 to 33% in 2018/19. The 2018/19 budget reports stated that social care now accounts for 40% of controllable spend
- In 2017/18 alone MCC experienced a 10.9% year on year increase in commissioned homecare hours (23,326 at April 2017 and 25,869 at March 2018);
- Provision for the National Living Wage for contractors has cost MCC around £19m from 2016/17 to 2019/20, on top of salary increases for Council staff. The Government did not provide additional resources to Manchester to fund this. In the proposed new model of Homecare, the specification states that providers are expected to pay at least the Manchester Minimum Wage (£8.75 per hour) which is higher than the National Living Wage (£7.50 for those aged over 25). Further work will be done on these issues in other parts of the social care including Residential Care and Learning Disabilities support.
- Failing markets for many commissioned services including residential and nursing care and homecare (domiciliary care), with many providers unable to run an effective business due to rising costs of labour, increasing costs of care, and the financial pressures facing local authorities and other commissioners that impact on the fees they can afford to pay

<u>Demographics: More people living with poor health outcomes</u>

- An increasing number of residents aged 65 and over, currently higher than in the last five years
- 8.2 years lower life expectancy for men and 6.4 years lower for women than the national level
- A healthy life expectancy that is far below the national level - just 56.1 years for men and 54.4 years for women, compared to 63.4 years for men and 64 years for women nationally
- The highest rate of premature deaths from diseases considered preventable of any local authority area in England - cancer, cardiovascular disease and respiratory disease
- A greater proportion of remaining life after 65 in poor health compared to the national average. Residents living longer but with higher levels of frailty linked to poverty
- A higher than average proportion of older residents with poor health outcomes and complex care needs due to the impact from wider determinants of health, such as long term unemployment and specific health behaviours
- High deprivation, which is known to cause or worsen poor health. Manchester is ranked 5th worst of 326 local authority areas nationally, and the 1st worst in the country on the health domain of the index of multiple deprivation
- Ethnic inequalities in health arising from an increasing proportion of residents from Black, Asian and Minority Ethnic (BAME) backgrounds
- In terms of the workforce, care sector jobs are relatively low paying and low skilled, within Manchester and nationally. There are significant risks from the implications of leaving the European Union given a large number of health and care jobs are filled by EU nationals. National Insurance registrations for EU workers have started to fall after being at record levels in 2015 and 2016.

There are opportunities to recruit more Manchester citizens to jobs in the social care sector, including younger people (Manchester has a relatively young population with proportionately more than average people of working age), but there needs to be a significant investment to make these roles more attractive, along the lines of the proposals to reform Homecare.

High and rising demand

- More than double the rate of alcohol-specific hospital admissions than the national rate
- A greater use of hospital services by older people than seen nationally
- An increase in the over 65s presenting with mental health needs, particularly dementia, saw an increase in people requiring support, from 164 at the start of the year 2017 to 188 at the end of the year
- During 2017 there was a net increase of 86 clients with Learning Disabilities

3 Properly funded, sustainable adult social care is fundamental to our ambitions and plans

3.1 Implementation of the Our Healthier Manchester plan is proceeding at pace. Manchester's plans are hugely ambitious, however they cannot happen without sustainable future funding of adult social care.

3.2 Manchester partners are integrating services on the ground for residents while undertaking radical structural change to organisations. The creation of a Single Hospital Service (SHS) is bringing three major hospital trusts into one organisation. Manchester Health and Care Commissioning (MHCC) has been established as a single commissioning function for the city, comprising City Council and three Clinical Commissioning Groups. The Manchester Local Care Organisation (MLCO) is live, in order to integrate community-based and out-of-hospital services – social care, primary care, mental health, and community health.

3.3 The strength of partnerships in the city is fundamental to this change. For example, the Partnering Agreement for the MLCO signed by all key partners – providers and commissioners, social care and health. There is a single Transformation Accountability Board for driving delivery of reforms funded by investments. A single set of priorities have been agreed for MHCC with agreed areas for investment in health and social care. There is a single commissioned budget for health and social care - however, the practicalities of making this work has highlighted just how chronically underfunded social care is.

3.4 The Manchester Agreement is an investment agreement that specifies the precise measures by which partners will reduce demand for acute health and social care services over the next five years. As demand is reduced for acute care, savings will need to be made, with finances freed up to re-invest in community-based services. This should be a virtuous cycle of investment, reform, savings, and sustaining investment.

3.5 The Our Manchester approach underpins how all of this change will happen. This involves putting people at the heart of everything we do, in new ways, to genuinely listen and understand what is important to them. The approach means recognising when staff are making assumptions, and starting conversations from strengths people have, not deficits. The Our Manchester behaviours – proud and passionate, listening, owning it, and working together – are a whole-system approach to changing cultures and ways of working, at all levels, including at the front line.

3.6 The Manchester Local Care Organisation (MLCO) went live on 1 April 2018. It has an ambitious strategy of leading local care and improving lives in Manchester, with our residents. The four aims of MLCO are:

- Promote healthy living
- Build vibrant communities
- Keep people well in the community
- Support people in and out of hospital

3.7 The four broad service areas for MLCO to achieve these aims are:

- Population health – improving population health and well-being.
- Primary care – integration and improving access.
- Integrated Neighbourhood Teams (INTs) – 12 geographical multi-agency teams that build integrated care around people and their lives, combining social care, community health, primary care and mental health – and linking outwards to other services and assets affecting the social determinants of health in neighbourhoods.
- Manchester Community Response (MCR) – intensive support where needed to help people move through the health and care system, including in and out of hospital, reablement, and crisis response.

3.8 The programme of adult social care transformation will involve:

- Adult social care teams effectively embedded within the 12 INTs with strong multi-agency working built around the residents of Manchester.
- Investing in new ways of working within social care that will reduce demand for acute services, including:
    - Extra Care housing schemes as a high quality alternative to residential care that maintains people's independence, and reduces inappropriate admissions to hospital. This means expanding from around 300 neighbourhood apartments currently to almost 1,000 by March 2020.
    - Expanding the reablement service to keep people at home for longer, reducing admissions and re-admissions to hospital, and delayed transfers of care. This means recruiting over 70 FTE staff to expand reablement, boosting the core service to meet demand, introducing a discharge to assess service, and an expanded offer for people with complex care needs.
    - Investing in new forms of assistive technology to support people to continue to live at home, independently rather than expensive homecare packages or placements in residential care, including electronic medication dispensers.
    - These and other schemes are built into the four service areas led by MLCO set out above, and link with other transformation investments

including High Impact Primary Care, Prevention offer to strengthen community links and social prescribing, enhanced Home from Hospital service etc.

- Changing behaviours in line with the Our Manchester approach. This means strengths-based working, putting residents at the heart of everything we do, workforces trusting each other and working together better – for example, strengths-based, trusted assessments so residents can tell their story once
- Workforce change being driven from the bottom-up including over 130 activators to champion change and a new approach to embedding strengths-based working.
- Applying new technology through a 'digital first' approach including shared care records for all patients, better use of health analytics including risk stratification, artificial intelligence, and assistive technology.
- Commissioning differently in line with the Our Manchester approach. For example a new model of homecare commissioned on an outcomes basis, with providers moving away from 'time and task', providing continuity of care, effective progression routes for workforces with higher pay and higher skills
- Programme of improving core social work practice within key services.

3.9 There is already some evidence of how adult social care reform is reducing demand, as part of health and social care integration. The challenge now is to rapidly increase the scale and pace of that reform, and to hardwire it into ways of working. For example, the Community Assessment and Support Service (CASS) has integrated Community Health, Social Care, Primary Care, Mental Health, and voluntary and community sector services in North Manchester. This approach is being scaled up through the Manchester Community Response approach in the MLCO. There is a particular focus in this approach on improving the interactions between in-hospital and out-of-hospital services. From January 2014 to December 2016 this service contributed to North Manchester significantly reducing rates of non-elective admissions (NELs) to hospital (by 14%, rising to 22% for 0-1 days length of stay) while NELs increased in both South Manchester (+12.7%) and Central Manchester (+2.1%).

3.10 All of these plans and ambitions cannot happen without sustainable future funding of adult social care. Manchester needs the certainty that sufficient funding will be available to meet continued increases in demand and cost, and that we can afford to invest in new ways of working and transformation. The alternative – continued lack of clarity and shrinking budgets – is to not invest in integration, scale back prevention and early intervention that keeps people well at home, reduce services to the core minimum – which will just shunt cost and demand onto other parts of the system, in particular to the NHS. Nobody in Manchester wants that to happen.

4 Funding options

4.1 We welcome the LGA's proposals for how to sustainably fund adult social care. Given the LGA's calculation of the national financial gap as £3.5 billion, the most important point is to ensure funds raised are on this scale. There also needs to be a commitment from Government that, whatever source of funding is found, the money needs to be committed to adult social care over

the medium term with clarity to allow for effective financial planning and investment locally.

4.2 Raising funding through national taxation

Of the options presented, our preference would be either

- 1 per cent on income tax, or
- 1 per cent on national insurance.

The advantages of these options are:

- They are on the right scale – they would raise more than sufficient funding to meet the national financial gap as calculated here.
- National taxation scheme allows for funding to be drawn from those who are most able to pay, and then redistributed to where it is most needed.
- The funds would need to be distributed effectively to local authorities, ensuring there is proper recognition within the funding formula for levels of adult social care need, including demographics, poor health outcomes, deprivation and other factors.

The other schemes outlined would not be preferred, for the following reasons

4.3 Means testing universal benefits

- Would not raise sufficient funding in the calculations presented here.
- Would create perverse incentives for some older people whose benefits become restricted, which damages their well-being and health, leading to further pressure on social care and health.

4.4 1 per cent increase in council tax

- The level of income that areas could raise through a council tax increase would be directly linked to each authority's council tax base, which is determined by property values and take-up of benefits. The council tax base of an area is not linked to levels of demand for social care.
- If anything there is an inverse relationship between the ability of authorities to raise money through council tax and levels of social care spend. Areas that are council tax-rich tend to have more people who can afford to fund their own social care, so the local authorities in those areas would have less need for the additional funding, whereas in a place like Manchester there are high levels of income deprivation in many parts of the city.
- Nationally, this option would represent a postcode lottery, disproportionately benefiting those living in areas with historically high house prices. For example, in Manchester, there are almost as many Band A properties (131,980 out of 226,310) as the whole of Greater London (136,840 out of 3,565,810 properties). In Surrey, only 1.8% of properties are in Band A - therefore a 1% increase in Surrey would raise over £7 million, compared to only £1.5 million in Manchester, where 58% of properties are in Band A.
- £1.5 million would fall well short of even paying for Manchester's estimated demographic pressures for adult social care, of £8.1m in 2019/20. This increase is driven by the growing numbers of people who require care and

support, and the estimated costs of National Living Wage for contracts, which is in excess of £4m.

4.5 Charging for accommodation costs in Continuing Health Care

- This option would also only raise a fraction of the amount required.
- It would also be very complex to administer given there are already a whole range of complexities between how local authorities and health account for the CHC services such people receive.
- There is a case for looking at CHC funding more generally as part of the wider funding reform given the challenges it creates in the system.

4.6 Other alternatives for the Government to explore would include:

- Means-testing services that are less health-critical within the NHS but are currently ‘free at the point of delivery’, particularly as care for conditions such as dementia through the social care system is not.
- Expansion of deferred payment schemes for individuals to use the value in their property to pay for their social care, recognising these already exist in some form and there are real barriers to their expansion.
- Reviewing benefits like Attendance Allowance and how they relate to social care, but recognising there is currently limited overlap between people receiving these benefits and social care, and that any additional revenue raised would probably be marginal and have to come from cutting benefits.

Local Government Association

FUTURE OF ADULT SOCIAL CARE

The lives we want to lead

The LGA green paper for adult social care and wellbeing

July 2018

Your views matter.

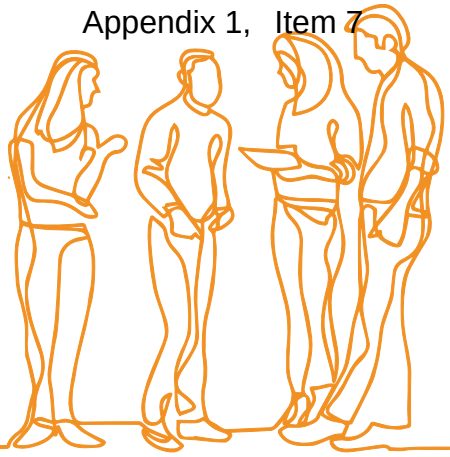
Our green paper is only a starting point and we want to build momentum for a debate across the country about how to fund the care we want to see in all our communities for adults of all ages and how our wider care and health system can be better geared towards supporting and improving people's wellbeing.

Throughout this green paper we pose a series of consultation questions and we would welcome your views on all those that are important to you. The consultation will run from 31 July to 26 September. Once the consultation closes we will analyse all responses and publish a response in the autumn.

To complete the consultation you can either visit **www.futureofadultsocialcare.co.uk** or you can submit your answers to the questions below to: **socialcareconversation@local.gov.uk**

If you are responding as an individual there is also an option to answer the questions in the 'Summary Green Paper' section which are primarily focussed on gathering experience-based evidence and opinions. You will find these at **www.futureofadultsocialcare.co.uk/summary-green-paper**

Contents



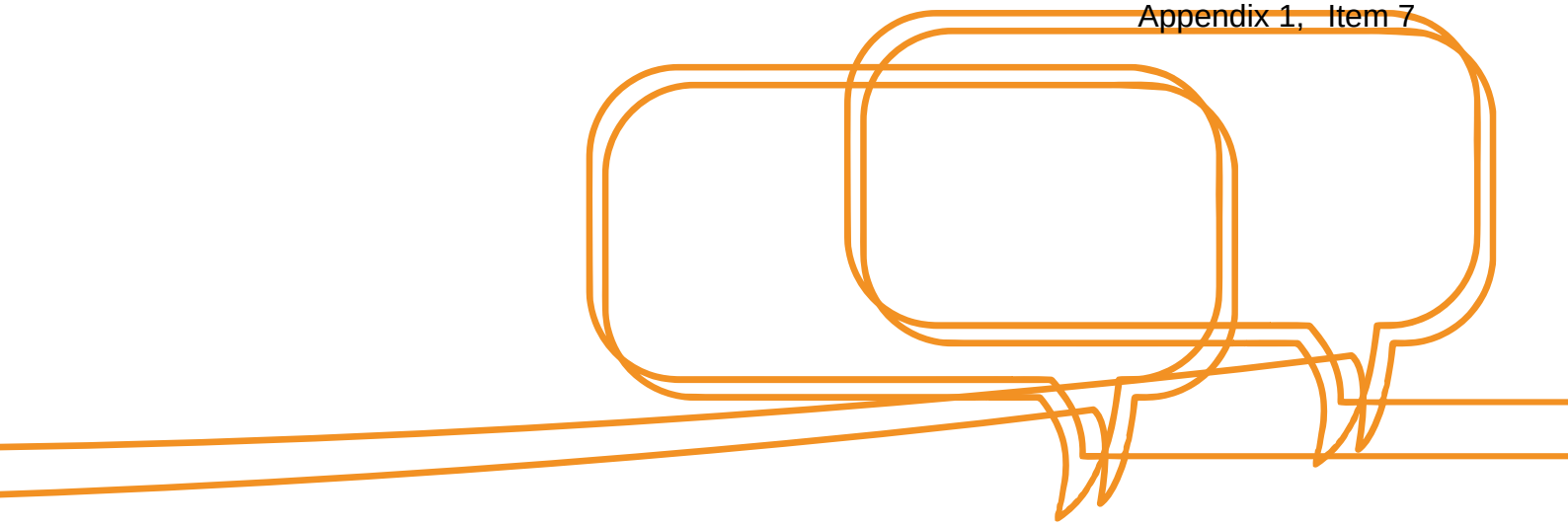
What our partners have said

"We support the LGA's objective to show how local government can be at the forefront of developing pragmatic solutions, this should be the time for an informed debate with the public on the future of social care. The absence of adequate, long-term funding and reform for adult social care has already had a significant impact on increasing demand both in the NHS and across council services. As a sector we want to support people to live independent, fulfilled lives and we have shown to be effective in doing this when we have the right tools and funding. Ensuring that people and place are at heart of any reform is the right approach to take – we now need to pick up the pace of planning to address the urgency of need."

Paul Najsarek,
Solace lead spokesperson
for wellbeing and Chief Executive
of the London Borough of Ealing

"Local government and the voluntary, community and social enterprise [VCSE] sector share a vision for social care which helps us all to live good lives in our own homes with the people we love. Immediate investment is needed to stabilise social care. Then councils and the VCSE sector must work with people who need support and their community organisations to co-design a social care system which intervenes early, sees the whole person and can stay with people and families for the long haul. Human, effective and sustainable approaches already exist: great councils have been pioneering their development. Now they must be scaled up and become the norm."

Alex Fox OBE, Chief Executive
of Shared Lives Plus
and independent chair of the
Joint VCSE Review



"The LGA publication of their version of a 'green paper' for social care represents an important contribution to the debate about what we want society to look like from one of the key contributors to delivering that future. ADASS will work with the LGA alongside all stakeholders in this critical debate to ensure the voice of adult social care remains prominent throughout. This document maintains a much needed profile in the lead up to the Government's formal green paper due now in the autumn."

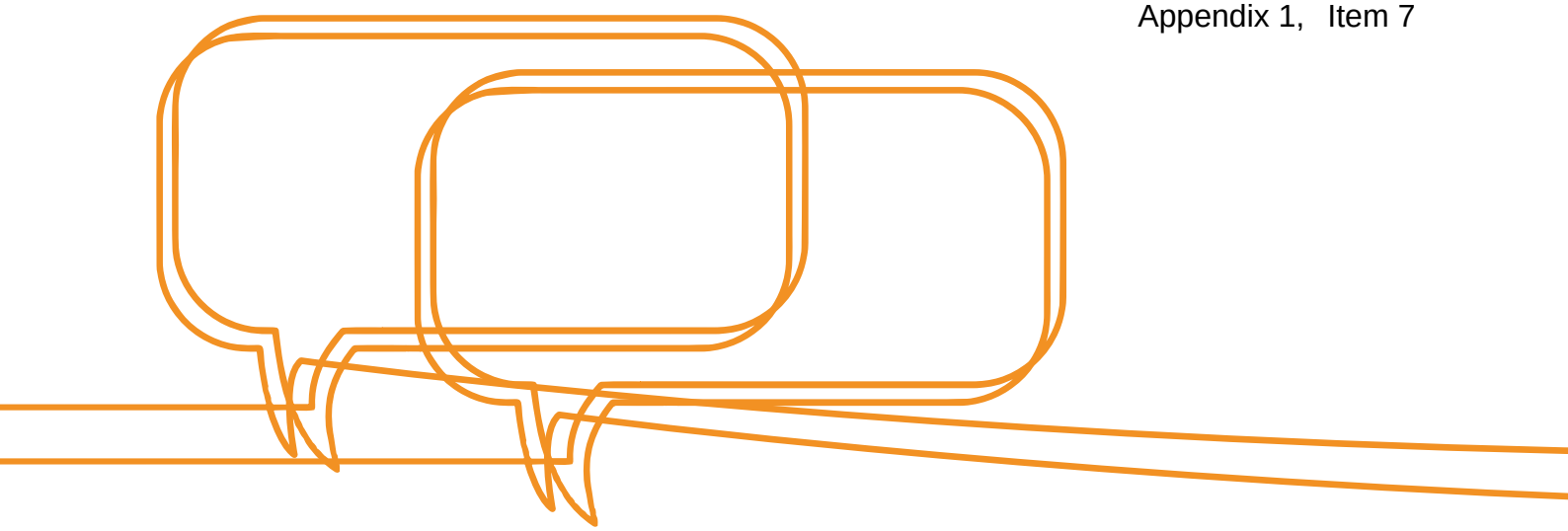
Glen Garrod, President of the Association of Directors of Adult Social Services

"It is vital that we keep the focus on the plight of social care, in spite of the succession of government postponements of their own green paper. The LGA is to be congratulated on keeping the debate going and we will respond to the issues it raises."

Niall Dickson, Chief Executive, NHS Confederation

"The issue of how to fund social care cannot continue to be avoided. Decades of indecision has led to one in three people with MS (multiple sclerosis) being denied the care they need and this can't go on. The LGA's consultation raises many of the key challenges that must be tackled, including the need for proper government funding and a fair system that works for everyone who needs care. We hope that when it does arrive, the Government's own green paper will set out a bold and ambitious plan that addresses these challenges. People with MS shouldn't have to keep paying the price for a system in crisis."

Genevieve Edwards, Director of External Affairs, MS Society



"Fixing social care has been stuck in the too difficult to-do box for far too long. This is not just about the money, it's also how we do care differently, make it more predictive, proactive and personalised.

"The Care Act provides a 21st Century framing for social care but it needs funding to deliver. By setting out its own green paper the LGA is demonstrating the sort of cross party dialogue and collaboration necessary to deliver the sustainable settlement we desperately need. We are running out of road for the Government to kick the can down."

Professor Paul Burstow FRSA, Chair, Social Care Institute for Excellence

"I am glad the LGA is continuing the debate for a long-term sustainable solution for adult social care. Of course funding and resources are a critical part of the debate but to ensure we focus on quality too, the needs and aspirations of all those using services, their families and carers, must be at the heart of what that future should be."

Andrea Sutcliffe CBE, Chief Inspector of Adult Social Care, Care Quality Commission

"We need to prioritise prevention to ensure a sustainable NHS, to ensure that people can enjoy the best possible quality of life using our hospitals less often and later in life. We can do this through helping people spend more years in good health, and when unwell, to stay in their own homes for longer. And as people retire later, we need to extend their healthy working life.

"40 per cent of all morbidity is preventable and 60 per cent of 60 year olds have at least one longer term condition. In 15 years we will have 1.3 million more people aged over 85, so prevention has to be at the heart of both the new NHS Ten Year Plan and the future work programme of its most critical partner, local government."

Duncan Selbie, Chief Executive, Public Health England

"We expect to see a fair and well-funded social care sector to enable older and disabled people to live the lives they choose. It is unfair that successive governments have continued to delay decisions about social care reforms.

"**The lives we want to lead** from the Local Government Association is a very welcome initiative. Where central government stalls, local government is helping to keep adult social care firmly on the agenda. We all need to engage with the questions in this report, raise the debate and fill the void left by central government's lack of policy progress."

Dr Rhidian Hughes, Chief Executive, Voluntary Organisations Disability Group and Chair, Care Provider Alliance

"It's great to see health and wellbeing at the very heart of this paper. We support this consultation and it's essential that the whole system comes together to agree a workable way forward. This must include a strong focus on prevention to deliver sustainable services."

Nicola Close, Chief Executive, Association of Directors of Public Health

"Social care and health are two sides of the same coin. The LGA's conversation about social care is vital to understand how we provide high quality, timely, cost effective support to everyone who needs it. Gathering views from the frontline about how we change has never been more important."

Saffron Cordery, Deputy Chief Executive, NHS Providers

"This LGA green paper consultation provides a great opportunity for everyone to comment and hopefully help inform the future shape of adult social care."

Lyn Romeo, Chief Social Worker for Adults, Department of Health and Social Care

"Big choices loom for social care policy: how much should the state help individuals with the costs of care? how should funding be raised to pay for that help? And what is the balance in responsibilities between local and national government? With such important and contentious issues, it is vital to consult widely and broadly with stakeholders and citizens to help build consensus on the way forward."

David Phillips, Associate Director, Institute for Fiscal Studies

Foreword

Adult social care and support matters.

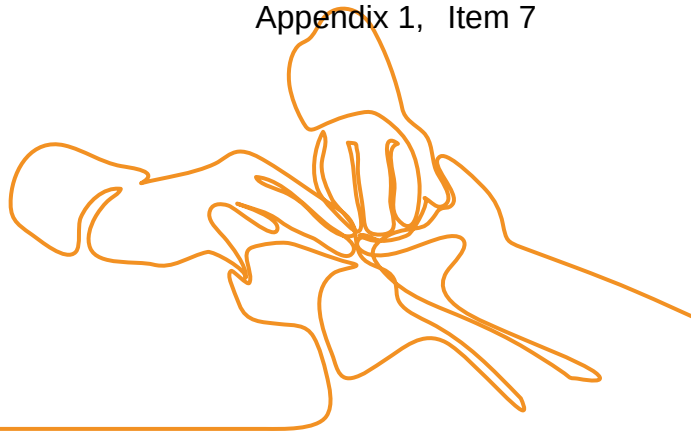
High quality social care and support helps people live the life they want to live. It helps bind our communities, it sustains our NHS and it provides essential economic value to our country.

The Local Government Association (LGA), like its many partners in the social care sector, has worked hard to ensure that the question of how to fund social care for the long-term has had the time in the national spotlight that it deserves. But we have still not secured the action we urgently need.

The continued absence of a sustainable, long-term solution has brought care and support to breaking point. It now also means that, across the country, local government is struggling to sustain universal local public services like roads and waste collection as it has to prioritise statutory duties like social care for children and adults, and support for the NHS. The failure to address this creates a deeply uncertain future outlook for people who use social care services now, and the growing number of people who will need the service in the years to come.

This is a collective failure that impacts most on the very people least able to help themselves.

National governments past and present have tended to put political prospects ahead of difficult but necessary decision-making. When they have put forward proposals, national opposition parties have sought to discredit them instead of trying to find common ground. The national media has latched on to this disharmony, further fuelling the politicisation of the question of social care funding. Faced with a frustrating political stalemate, the wider social care sector at times inevitably seeks to rebuild momentum by focusing on the 'crisis' in care, despite knowing better than most that a more balanced narrative that emphasises the inherent value of social care is more conducive to winning hearts and minds. The preoccupation of successive governments with the state of our hospitals has impacted on the use of new money for social care.



The result is at least two decades in which the question of how to fund social care for the long-term has never enjoyed more than a few brief periods in the national spotlight. All the while, the concerns and experiences of the people who matter most – those who need care and support and their families – have struggled to get the attention they deserve. More widely, the public has largely remained detached from the debate, finding it difficult to engage with a set of questions and issues that have so many conflicting viewpoints. Most people still do not have a good sense of why social care matters, how it works and how it is funded.

Against this backdrop, the approach of governments past and present in dealing with mounting pressures in social care has been to limp along with piecemeal measures from one year to the next. Local government is widely acknowledged as the most efficient part of the public sector and councils, along with providers and third sector organisations, have responded admirably to help maximise every pound and drive innovation in the interests of people and the public purse. But with demand growing, costs rising, people's expectations rightly increasing and funding declining, this approach of short-term sticking plasters must be abandoned. The need to resolve the long-term future of care and support is now urgent.

We cannot duck the issue any longer.

It is time to confront the hard choices, be honest about the options and make some clear decisions.

We need to come together as a society and be positive and inspiring, making the case that investment in social care and support for people who need it helps them to reach their full potential and, in turn, our nation's.

Across the country there are many examples that show how our sector has innovated and transformed itself through world-leading initiatives such as direct payments. Positive futures for care and support, which draw on all the assets of councils, communities and civil society, can already be glimpsed and built upon.

The Government's recent decision to delay its own green paper is disappointing and frustrating. In the context outlined above, it is also hardly surprising. More importantly, it provides an opportunity for local government – so often the pragmatic front-runner on difficult agendas and at the forefront of developing solutions to difficult issues on a cross-party basis – to seize the initiative and take the lead in forging a way ahead. That process begins here with the LGA's green paper for adult social care and wellbeing, The lives we want to lead. It is supported by all political parties within the LGA, demonstrating the required level of cross-party support amongst local politicians that we need to see matched by our national politicians.

Much of our green paper is about the future of care and support for all adults and how we pay for it. But if our starting point is the individual person and what is important to them, then one service alone can never support them to live the life they want to lead, no matter how good it is. Our green paper therefore looks beyond social care and considers the importance of housing, public health, other council services, including those delivered by district councils, in supporting wellbeing and prevention, and the vital work with councils' local partners, families and communities. And of course, we consider the NHS. This year we rightly celebrate the 70th birthday of our health service, but if we are to look ahead with confidence to its centenary then it too must change for the benefit of those it serves.

This is therefore a green paper for wellbeing. It seeks to lay the ground to secure both immediate and long-term funding for social care as well as make the case for a shift in approach from acute treatment to community prevention. It is about people, population and place, not structures, systems and silos. It is also just a starting point. Too often policy is developed in isolation. With this green paper we are seeking as wide a selection of viewpoints as possible, recognising that this is complex territory. There are no single or easy solutions and even within the sector there are different views on how we should move forward. Throughout this publication, we therefore pose a series of consultation questions to understand those views and identify where there is consensus or overlap. We encourage you to respond. We have also produced a separate set of tools to help gather the views of the public which you can find on our website **www.futureofadultsocialcare.co.uk**. Your support in promoting these would be valued as we seek to reach as wide an audience as possible on the questions at the heart of the debate.

We want to build momentum and help stimulate a truly nationwide debate about how best to fund the care we want to see in all our communities up and down the country for adults of all ages, and how our wider care and health system can be better geared towards supporting and improving people's wellbeing. We will reflect on our consultation findings in a further publication later in the autumn, in time to influence the Government's plans; not just their green paper, but also the Budget, the NHS Plan and the Spending Review. This is our chance to put social care and wellbeing right at the very heart of the Government's thinking.

We have a vision for people's wellbeing that is rooted in local areas and backed by clear and strong local democratic accountability. It is about helping to build a society where everyone receives the care they need for a good life: well, independent, at home for as long as possible and contributing to family and community life.

It is our time to drive this agenda forward.

Lord Porter of Spalding CBE
LGA Chairman

Cllr Nick Forbes
Labour Group Leader
and LGA Senior Vice Chair

Cllr James Jamieson
Conservative Group Leader
and LGA Vice Chairman

Cllr Howard Sykes MBE
Liberal Democrat Group Leader
and LGA Vice Chairman

Cllr Marianne Overton MBE
Independent Group Leader
and LGA Vice Chairman

Executive summary

We all strive for a happy and fulfilling life. We should all have the support we need to live one. Many of us can live the life we want without much, if any, help. Others may need a great deal, receiving it from a range of sources including family, friends, neighbours, community and voluntary groups, and statutory services. What matters most is that everyone can exercise their right to opportunity, independence and control.

Too often adult social care is seen as an adjunct of the NHS, existing simply to relieve pressure on hard pressed acute services. While it is true that social care and the NHS are inextricably linked, it should be seen an essential service in its own right and the people who work hard to deliver the service should be seen as just as valuable as staff in the NHS. It helps people with life-long disabilities, those who acquire disabilities during adulthood, older people with care and support needs and unpaid carers of all ages to live their lives with dignity and in the way they see fit. But it is more than that. It creates services and partnerships – particularly with the voluntary sector – that help strengthen our communities, it allows the NHS to focus on what it does best and it is important for the future of our economy and national productivity; as the Government's own Industrial Strategy acknowledges, helping people to live independent lives and continue to contribute to society will create "an economy which works for everyone, regardless of age'[1].

People working in local government care passionately about adult social care and take pride in the role it plays in supporting people's lives and improving their outcomes. With the right level of funding, councils can continue to make a positive difference to people's wellbeing. With the right level of freedoms and flexibilities, they can work with health and community partners to drive local action across the public, private and voluntary sectors to reshape care and support around the needs of individuals and in the communities they cherish. With the right training and career opportunities, good quality staff can be attracted to the sector and, as importantly, stay in it. Adult social care has a central role to play in this. But it is also embedded in a wider network of local government services and functions which promote health, independence and wellbeing: all council services contribute to health and wellbeing.

Whilst councils and their partners have a strong story to tell on improving people's wellbeing, progress to date is now unquestionably at risk. Local government has kept the worst consequences of austerity at bay in recent years but its impact is now catching up with councils, threatening services that improve our lives and our communities. This is certainly the case with adult social care and the service now faces a funding gap of £3.56 billion by 2025. This must be closed as a matter of urgency. If it is not, we will see a worsening of the consequences of funding pressures we have seen to date. These include fewer people being able to get the high quality care they need, providers under increasing threat of financial failure,

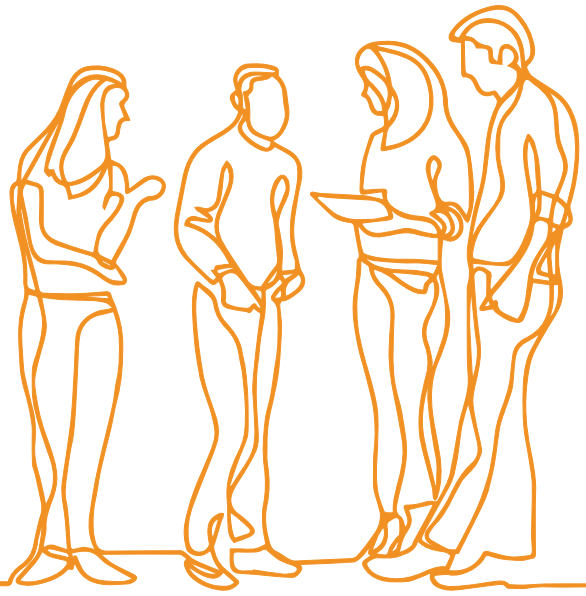
1 https://www.gov.uk/government/publications/industrial-strategy-the-grand-challenges/industrial-strategy-the-grand-challenges

and a disinvestment in prevention driven by the requirement to meet people's higher level needs. In particular, funding pressures on social care have severe consequences for the NHS, increasing demand on hospitals and more costly acute care. Of course, this is a two-way street and what the NHS does or does not do can impact equally on social care. Reductions in services such as incontinence treatment, stroke rehabilitation and NHS continuing care increase pressures on social care. We know these problems are only going to get worse as demand grows with the needs of our ageing population. The question of how we pay for adult social care for the long-term is therefore getting even more urgent. The fact the question has remained unanswered for at least the last two decades shows the scale of the challenge.

In part, that difficulty stems from a lack of awareness amongst the public of what adult social care is, why it matters and how it is funded. Not so in the NHS, which people intuitively understand, both morally and operationally. By paying our taxes we pool the risk and cost of treatment we may need if we become sick. We pay in, the NHS pays out, free at the point of delivery, free at the point of need. It is a simple equation and a powerful contract between citizen and state.

It is a far less clear cut picture in adult social care. Not all care needs count as 'eligible' for support under the legislation, and the amount you have to pay depends on the level of your own financial resource, which itself is treated differently depending on whether you receive care at home or in a care or nursing home. If you have more than what many would say is only a modest degree of savings, you pay for everything yourself becoming one of a growing population of 'self-funders' who are largely left to navigate the system themselves and make their own arrangements. Without the right information and support, wrong decisions can be made, personal savings can reduce rapidly and people fall back on publicly-funded care, compounding the pressure on local services[2].

2 See, for instance, https://www.lgiu.org.uk/wp-content/uploads/2012/04/Independent-Ageing.pdf



The situation is often summed up by the simple example of cancer and dementia. Develop the former and the NHS will, in general, take care of you for free. Develop the latter and you risk losing the majority of your savings because you will have to pay for your care. This inevitably raises a host of questions which tend to gravitate towards a broad idea of 'fairness'. Over the years this has been articulated in different ways, whether it be about people who have paid taxes all their lives, those who have saved and made provision for the future, the importance of protecting people's housing assets, the opportunities different generations have (or have not) enjoyed, and how we should approach a person's ability to pay. Fairness means different things to different people, but the level of concern clearly points to a pressing problem that needs to be resolved. The question here is therefore twofold: how can we change the system for the better, and how do we pay for the changes involved?

Even answers to these questions will not bring about the change we need. Securing the long-term financial sustainability of adult social care is of course important. But the benefits of sustainable social care will be even greater if our wider care and health system can be made to work better as a whole. This requires a fundamental rebalancing of priorities – moving away from treating long-term conditions and illness caused by ageing and lifestyle factors and moving towards community-based models of both early intervention and support. There are many potential benefits of health and social care working more closely together and the role councils can play in commissioning, particularly in terms of NHS community-based services integrating with adult social care. It could also help to manage pressures on public spending more effectively. This would help maximise people's health, wellbeing and independence for as long as possible, and continue to take a whole-person and whole-family approach to those who develop support needs.

We have many of the key ingredients that are needed to help bring about this shift and focus investment in low cost prevention and support to help bend the demand curve for high cost health care. Under councils' stewardship we have a better performing and more cost effective system of public health. We have significant new funding for the NHS. In health and wellbeing boards we have a means of joining up clinical, professional and service user voices. We have led the way in re-designing services with – not for – citizens, and we work imaginatively with provider organisations and the third sector. Most importantly, we have democratic accountability through local councils. It is clear we are not starting from scratch. The question here is what level of change is needed to realise the full potential of each of these components?

Through this green paper we want to open up the debate on the core questions outlined above. Our focus in this work is people, and councils across the country want to rise to the challenge and do our bit to make sure people get the care and support they need to live the lives they want. We know that driving continuous improvement amongst councils is just as important as bringing about changes required in other parts of the sector. Whether that is improving our performance, working better with our health and community partners or taking greater responsibility for leading change locally; councils can do more and are committed to doing so. We will need to take risks, scaling up the most successful of the many innovations we have developed and supported. And we know there are no easy answers and that any additional investment must deliver real benefits for local people and communities. This is particularly true for people from black, Asian and

minority ethnic (BAME) backgrounds and other excluded groups who do not yet enjoy equal access to social care consistently: delivering on equalities will be a key test of any new system. The stakes are high. A failure to be bold today will impact on people, our communities, our hospitals and our economy tomorrow and for decades to come.

Our green paper deliberately steers clear of pushing particular solutions at this stage. Instead, it articulates why this debate is so important, the scale of the challenge and the sorts of questions we need to tackle to drive the conversation forward. We will work with our many partners to engage professionals, politicians, people who need care and support and the public alike in the weeks ahead, before producing a further report in the autumn that reflects on our consultation findings. We hope this will help shape the Government's own green paper, moving it more towards actual solutions, rather than consulting on territory that has been covered before.

Chapter one of our green paper sets the tone for the remainder, starting with the most important voice in the debate: the people who use services to help them live the life they want to lead. In chapter two we recognise that we are all unique and therefore require different support to fulfil our ambitions. Wellbeing is defined and the role of local government and the wider public, private and independent sectors in supporting this is briefly explored. Chapter three sets out the case for change – why social care matters, how the sector has delivered in challenging times and how it remains committed to doing so, and the scale and consequences of underfunding. In chapter four we explore some of the attitudes and beliefs of the public and other key groups in the debate about the future of long-term funding for social care. We set out a series of options for changing the system for the better before setting out a second set of options for how we might pay for those changes. Chapter five moves the debate along to consider the wider changes we need to see across care and health to help bring out a greater focus on community-based and person-centred prevention. It looks at the role of public health, other council services and those of councils' partners in supporting and improving wellbeing. Chapter six continues this wider exploration of issues by looking at the nature of the relationship between social care and health, integration, accountability and how the new NHS funding could be used for maximum impact.

Who is this green paper aimed at?

"All too often, the funding of adult social care is seen as an economic and a technical issue: what's the best mechanism for raising the funding we need? While this is important, the more fundamental questions are personal, political and philosophical: what kind of life do we want to have together as a society? How much do we value disabled and older people with care needs? What sort of support would we want available to any of us if we needed care? How much do we really value this and how much might we therefore be prepared to pay for whatever quality of life we decide we want?"

Professor Jon Glasby,
University of Birmingham
LGA think piece series, 2018

Questions about the future of adult social care and support, and the wider changes we need to make to our care and health system to improve wellbeing, should be everyone's business. They are questions that impact on us all – in our personal and professional capacities, as members of local communities, and as citizens of wider society.

For this reason, our green paper and accompanying consultation aims deliberately high. It seeks the views of people who use care and health services and their carers, people who are experts on various elements of these services, and people who have no knowledge of the system at all. We are ambitious precisely because the views of all these people matter.

We want to hear from:

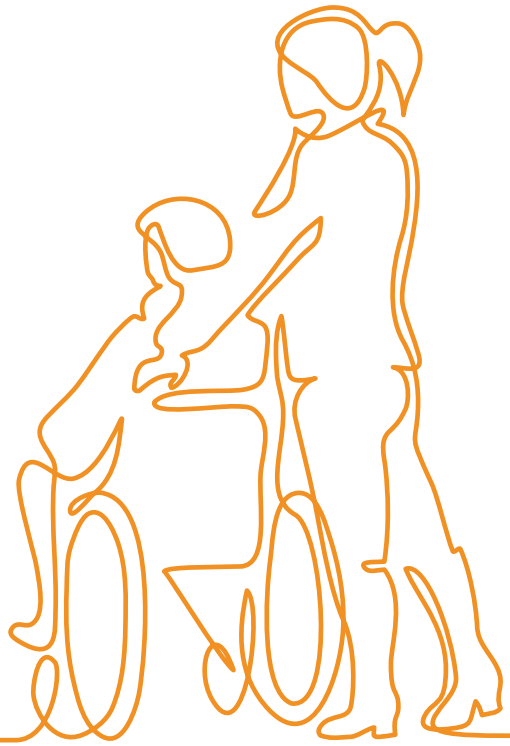
People who use services and their carers: your wellbeing is what matters most and your experiences and expertise should be the single most important force in understanding and shaping the change we need to bring about.

Local and national politicians: as representatives of us all it is in your gift to help bring about the change that is sought – promoting it, putting it on the map and helping to deliver it.

Professionals involved in the commissioning and delivery of care and health: your knowledge of the operational aspects of care and health can help identify all the barriers to progress that need to be overcome and how we might do so.

Public: the chances are that you, or someone you know, will at some point have contact with social care, be that needing services, working in the sector, or being an unpaid carer for someone you love. What you would want for yourself, or someone you care about, must shape the future.

All of us: we cannot move forward without knowing our level of ambition and what we are willing to pay to achieve it.



Adult social care at a glance

Councils spend over

£15 billion

on social care every year.

Demography, inflation and National Living Wage pressures means that the gap in adult social care funding will be

£3.56 billion by 2025

(just to stand still)

This is more than five times the amount spent annually on councils park services and close to the cost of councils waste management for a year (£3.6 billion)

By 2019/20 councils could be spending as much as **38 pence out of every £1 of council tax** on adult social care

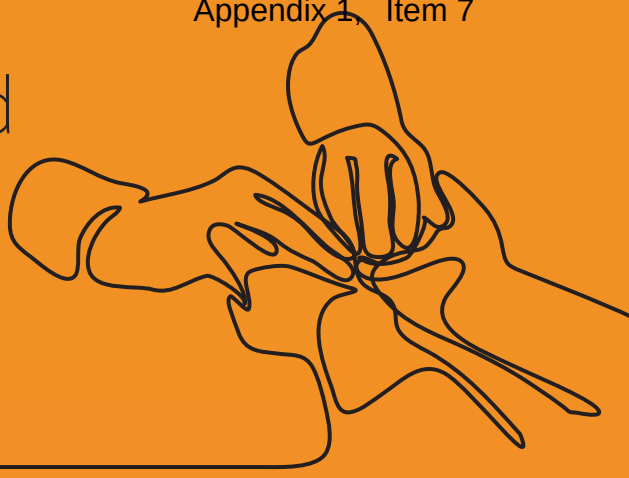
This is up from just over 28 pence in 2010/11. As councils spend more on social care, less money is available to keep valued local services running

The provider funding gap is putting providers under impossible pressure

In more than **100 council areas** residential care home and home care providers have ceased trading, affecting **more than 5,300 people** in the last six months. This is a direct result of funding pressures.

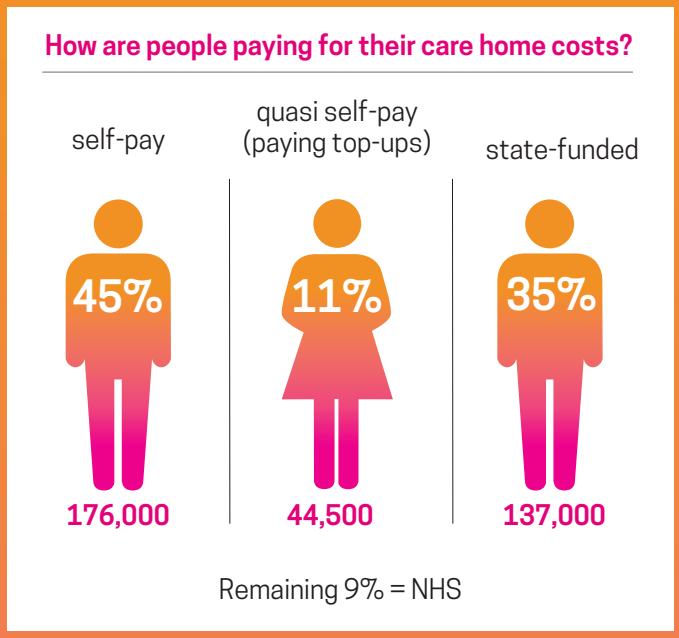
The lives we want to lead

The LGA green paper for adult social care and wellbeing



Carers UK shows that **72 per cent of carers in England have suffered mental ill-health** as a result of caring and **61 percent** had suffered physical ill health

Our care system could not survive without the vital help from unpaid family carers.



Source: Care Homes for Older People, 29th Edition, Laing Buisson

Age UK estimates that there are **1.4 million older** people who do not receive the help they need.

That includes **164,217** people who need help with three or more essential daily activities like washing, dressing and going to the toilet but **receive no help at all from either paid services or family and friends**.

FUTURE OF ADULT SOCIAL CARE

1. The voice of people who use services

People must come first. Organisations' structures, governance, strategy, policy and partnerships all matter. But they must only ever be secondary, serving to help a primary aim of understanding people's aspirations, needs and the support required to live a life.

There is no such thing as a 'typical' person who uses health and social care services. Every individual who needs help and support has their own unique set of circumstances, needs and assets. And there are no neat and clear-cut categories of people who require adult social care and support. Instead, there is a complex interplay between mental and physical conditions that has to be taken into account when deciding the best care and support package. For example, people with learning disabilities have a higher prevalence of mental health problems compared to those without[3]. More than 15 million people – 30 per cent of the UK population – live with one or more long-term condition(s) and more than four million of these will also have a mental health problem[4].

Our first full chapter therefore starts with the voice of people with experience of our care and health system, illustrating the diversity of people supported by the social care and support sector. These are powerful stories, which at times are hard to read. They expose – in the most human terms – the consequences of a system that lacks all the tools required to be the best that it can be for people that need it. They are also a challenge to us all to keep this subject firmly on the public and political radar.

As you read through our green paper and consider the questions it raises, we encourage you to return to these stories as essential grounding in why this debate is so fundamentally important to the future of people across our country, and our country itself.

3 Cooper, S.A., Smiley, E., Morrison, J., Williamson, A., & Allan, L. (2007). Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors. The British Journal of Psychiatry, 190, 27–35.

4 Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossy, M., & Galea, A. (2012). Long-term conditions and mental health – The cost of co-morbidities. London: The King's Fund, & Centre for Mental Health.

Josie's story

At the moment, I get three short visits a day from a care worker to cook my meals, help me shower, and keep the house clean.

I get two hours every two weeks 'social' time which at best on a good day gets me over to the park and back. It's not long enough to join in any activities but I value this time hugely as it's uninterrupted time with actual real conversation, not just "what do you need to eat?" or similar.

My basic needs are met – I'm clean and I'm fed. But I haven't got enough support to actually get me out of the house. It means that some days I barely get to speak to anyone, let alone have a social life. If I get an infection and have to ask my carer to pick up a prescription, I don't get to have a shower that day. There just isn't enough time. A little more support – for example, a support worker to go with me to new places – would give me so much more opportunity to take part in life, but at the moment that feels like an impossible utopia!

People like me, who were professionals and could make a contribution with the right support, are being cut out of the workforce. Working in an office or a hospital isn't really possible for me, but I still have skills and experience that I would like to use, if I had the means of doing so. In the end, it is a question of equality. I don't feel like I'm living, just existing.

Vicki and Keegan's story

I was diagnosed with Muscular Dystrophy when I was young. As a degenerative condition every day is an increasing challenge.

I am now 36 years old and I need assistance to get out of bed, to eat, to use the bathroom and to leave the house. I need someone with me day and night.

My partner Keegan cares for me around the clock. If he didn't, I would need a full-time carer or I would have to live in a residential home. Yet, Keegan is only paid for four hours a day and we have no funding for respite. I worry every day about what would happen to me if he couldn't look after me anymore. He is my independence and my dignity.

In the past I have been offered some support to help me at home but as my condition worsens and my needs grow, I am being offered less and less because there is no money available to help me. Something as simple as getting a hoist to help me in and out of bed has become a battle. At times, this has meant that my more preventable symptoms have got so bad I have had to call an ambulance. I am only too aware that every minute I spend with paramedics is taking this costly service away from someone else who needs it, but I am left with no choice. Sadly, I am not the only person I know who has to do this and while I want to feel positive about the future, if I keep being told there is no money for the help me and Keegan need, we feel totally helpless.

It's hard enough living with this condition without feeling like I have to face a challenge every time I ask for help. The sad thing is none of us know when or if we will need people to care for us one day so it is vital that everyone is aware of the issues before it is too late to do anything about it.

Glyn and Kristin's story

My wife Kristin is just 47 years old but has had Multiple Sclerosis for 17 years. Each year, as it inevitably progresses, it becomes a bigger aspect of our life together.

I was caring for Kristin at home but just two years ago this became too much and I collapsed under the strain. We had carers coming in morning and night to get Kristin in and out of bed, but all other hours of the day I was left to care for Kristin on my own.

At the same time, I was trying to run my own business to supplement the modest carer's allowance I received. I got no respite and was exhausted.

Kristin fell ill with a simple respiratory issue and got stuck in hospital for three months because she wasn't allowed to leave until a package of full-time care was in place. When she finally left hospital she came home for four months until I collapsed from looking after her with no respite.

She was then placed in an NHS funded nursing home under the continuing healthcare scheme. I think she could have come home full time with the right care in place or if the money being spent on her care home was invested in making the right adaptations to our home. Devastatingly, the council couldn't pay for all of the changes we needed and I couldn't fund it on a reduced income so we had no choice.

It's so hard for people who are not in our situation to understand the enormous impact this has had on our family. Kristin is the most important person in the world to me and I still find it hard that instead of spending our lives together she is left feeling isolated in a home where she is the youngest person by many years. I see her every day, but I miss her terribly and feel so guilty every time I leave her there.

Before Kristin became ill we had never considered that we might one day rely on carers, which terrifyingly made us realise this could happen to anyone – young or old. What is important is that we have a system that makes sure people get looked after in the way they want because that's the very least we all deserve.

Sandy's story

Mum was diagnosed with dementia in her early 70s. Dad cared for her at home for many years until the stress became too much and he had a heart attack. We then tried to access home assistance from the local council, but this proved impossible.

The only real option was to move Mum into a care home. Dad sold the family home and bought a small bungalow nearby. We all contributed to the top up fees for over seven years, amounting to hundreds of thousands of pounds. We then tried to access NHS funding for Mum, who was by now in an advanced stage of dementia. [She was] doubly incontinent, no longer able to communicate verbally and unable to feed or dress herself. The funding was refused. We couldn't understand why.

Eventually we negotiated social care funding for Mum. However, the amount the council pay is significantly less than the fees charged. This subsidisation by private payers is another example of a system riddled with inequalities.

Our Mum is elderly, vulnerable and unable to vote. She no longer has a voice and has become effectively disenfranchised. So we must speak for her and others like her. Society is judged by its treatment of the elderly and this state of affairs is nothing less than shameful. Dementia is an illness. We cannot throw our hands up and say it's all too difficult.

Governments can no longer turn a blind eye and say we can't afford it. We have to act now to ensure that people affected by dementia are treated fairly and properly. We must fund a social care programme which will allow the most vulnerable in our society to be cared for in an environment which allows them to live with dignity. Government must step up to the plate and be honest with the electorate.

This situation is not going to go away. Everyone affected by dementia, either those living with the disease or their carers and relatives, deserves so much better.

What adult social care and support desperately needs: sustainable funding for the long-term

Steve's story

I was living with my partner, running a B&B when I had a serious stroke and later two minor heart attacks. After four months in hospital, I was depressed, frail and my memory and cognition had deteriorated.

We knew I needed more support with daily living than my partner could provide. I was unable to return home and it made me frightened about my future, with clinicians uncertain about my further recovery.

I wanted to live locally, so I could continue seeing my partner and I missed my dogs. The Shared Lives scheme matched me, with two trained and approved Shared Lives carers who shared my sarcastic sense of humour, had dogs, and lived close by. They helped me through it all. When I arrived at their home, I never dreamt of being so independent again. I couldn't walk down the drive. Now I can nip up to town.

My Shared Lives carers helped me gain strength and confidence, walking a little bit further each time, until I could walk independently again. They helped me adapt to my memory loss with strategies for managing money and banking, and supported me to make meals and manage my diet.

Since then I have booked a holiday and travelled on my own. I am very optimistic about life and planning a move into my own flat.

Without the Shared Lives scheme I would have undoubtedly spent longer in hospital, had less choice about where I lived, and had a slower recovery. It is so important that money is available to ensure that schemes like this exist.

Lucy's story

My daughter Lucy has a learning disability and spent 12 years in hospital after being sectioned under the Mental Health Act.

Lucy went through a very stressful time in her life which was when things started to go wrong for her. This caused her to suffer from severe anxiety. She began having more epileptic seizures. When she was hospitalised, we struggled to get her out. As a family, we didn't know what to do or where to get help. After 12 long years Lucy came out of hospital, supported by the local commissioner and a care and support provider who worked with Lucy and us to plan what she needed and wanted from her life.

They worked with us and Lucy while she was in hospital and supported her transition back into the community. They really helped us to know what was possible. They really listened to us.

Lucy now lives in her own bungalow, close by to us. She is supported by a staff team that she chose and who are trained to support her in a way that works for her.

When she first came home she was very shy and didn't go out much. Now her confidence has really grown and Lucy has joined the empowerment steering group for the Transforming Care programme, to help improve services and support for people with a learning disability, autism or both. She is learning to travel independently and loves to do the things that we all take for granted – like going out and about, visiting us but most importantly her niece, and looking after her cat, Smudge.

Good support is about saying that people have a right to a good life in the community with the right support. Lucy is doing really well, but there are always worries in the back of your mind that something will change and the support might stop or get less. We need to recognise that good support now will prevent more expensive hospital stays down the line.

2. Delivering and improving wellbeing

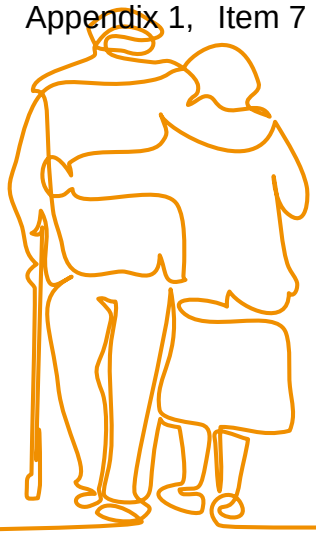
"Local government has many responsibilities but none more core than creating places that are inspiring of good health, leading improvements for local people, encouraging businesses to grow and creating jobs that local people can get. By being ambitious for the health of local people they can create years full of life as well as life full of years."

Duncan Selbie, Chief Executive, Public Health England
LGA think piece series, 2018

Key points:

- We are best able to live the life we want to live if we are independent, well and live in communities that support and encourage the many aspects that make us unique
- This is true for everyone but the support we may need is unique to us as individuals and must therefore be personalised
- Local government exists for this very purpose, affecting multiple dimensions of our communities and lives, throughout our lives
- Supporting and improving people's mental and physical wellbeing is at the heart of local government's work and that of many other local public, private and voluntary sector organisations. It can only be delivered with communities

"I am very optimistic about life and planning a move into my own flat" Steve's story



Our lives are precious and unique and we want to live them as we each see fit.

For the benefit of those who need support to live the life they want to lead, we must start by asking the individual person, **'What matters to you?'** rather than **'What is the matter with you?'** However, starting the conversation this way, with the right question and full emphasis on personalisation, means little if we do not have what is required to act on the answer.

Acting most effectively means changing our model of care and support from one which tries to treat the ever-growing burden of long-term conditions and illness caused by demographic and lifestyle factors – doing to the person – to one which helps people maximise their health, wellbeing and independence for as long as possible – doing with the person at all stages of their life. Changing the model in this way requires an equal partnership between local political, clinical, professional and community leaders in which each area develops its own vision and range of services to suit their own unique local circumstances.

Many services support the process of wellbeing. The police service deters, detects and deals with crime. The NHS treats us when we are ill. Our education system helps us learn and be curious. But as essential as these services are, they ultimately only really focus on one element of our lives. And while we alone tend to shape our own aspirations, it is the places in which we live, grow, work and relax that give us opportunities for fulfilling lives and the confidence that the choices we make will result in safe, quality and rewarding experiences.

Local government helps shape the fullness of the places in which we live. From the mix of shops on our high street to the removal and recycling of waste, councils lead and engage with their communities to deliver more than 800 services. This helps keep every aspect of our communities running and improving for the benefit of all people.

Because our lives do not start and stop, neither do councils. Local government services operate both in the background of all our lives and more at the forefront of others'. Councils support people at some of the happiest moments of their lives and some of the hardest.

At the heart of every council's relationship with its local population is a commitment to improving people's physical and mental wellbeing. This is a tradition that can be traced back through the decades as local efforts have pieced together to improve our nation's wellbeing. In more recent times it found expression in the 2014 Care Act, which cemented the idea that a council's general responsibility in respect of the legislation is to promote an individual's wellbeing. Helpfully, this was defined in broad terms, recognising that a person's wellbeing is shaped as much by their participation in work and their personal relationships, to name but two examples, as it is by the practical support they may need with daily tasks such as washing, eating and dressing.

In this way, wellbeing cannot and should not be the preserve of adult social care and support alone. If we are serious about preventing ill health we need a strong public health offer. If we are to help people remain independent at home we need the right kind of housing and neighbourhoods. If we are to encourage physical activity we need vibrant leisure and recreation amenities. If we are to combat loneliness we need reliable transport links, a diverse and resilient community and voluntary sector, and comprehensive employment services. If we are to support people's mental wellbeing we need to build safe and inclusive communities. The list could easily continue.

Wellbeing goes well beyond local government. The essential input from the local voluntary sector, the care provider market and its workforce and the local NHS all have a clear and fundamental role to play in creating local places where wellbeing can thrive. It is precisely because this is a local endeavour that councils, as democratically accountable local leaders of place, are perfectly positioned to marshal all local aspiration and resources around a common vision for a population's wellbeing and independence.

CONSULTATION QUESTION:

1. What role, if any, do you think local government should have in helping to improve health and wellbeing in local areas?

3. Setting the scene – the case for change

"Adult social care…matters because it's fundamentally about the business of protecting people's rights as individuals."

Lyn Romeo, Chief Social Worker for Adults
LGA think piece series, 2018

"What is clear to me is that local government in general and social care in particular have the advantage of being close to communities, being of those communities and able to take decisions where consequences are clear to us because of our perspective and our roots."

Glen Garrod, President, ADASS
LGA think piece series, 2018

Key points:

- Social care and support matters to individuals, our communities, our NHS and our economy
- The local dimension of social care matters because it ensures the service is accountable to local people
- Despite a challenging financial environment, social care has delivered – it has improved and innovated
- While diversity of local care and support is the positive result of a health and care system that is responsive to the diversity of the community it serves, unwarranted variation in quality, access and outcome is not acceptable. Local government is committed to addressing this and is best equipped to lead improvement.
- Significant reductions to councils' funding from national government is now jeopardising the impact local government can have in communities across the country
- In particular, the scale of funding pressures within adult social care threatens progress made to date and now risks people's wellbeing and outcomes and the stability of the wider system
- There are continuing recruitment and retention challenges in the adult social care workforce
- The Care Act remains the right legal basis for social care but funding pressures are threatening the spirit and letter of the law

"Good support is about saying that people have a right to a good life in the community with the right support" Lucy's story

Why does adult social care matter?

Living the life we want to lead

The first publication in the LGA's recent think piece series[5] on the future of adult social care and support posed the question: why does social care matter? A clear picture emerged from across our expert contributors that the core value of social care lies in supporting people of all ages, with a range of mental and physical health conditions and needs, to live with maximum opportunity, independence, connection to others and control. This is the core value of adult social care and support: it helps people to live the lives they want to lead, building on their own aspirations.

A service that we are all connected to

One in five people have some contact with the social care and support system. That might be as part of its workforce, as a user of services, or as one of the millions of invaluable unpaid carers[6]. Therefore, while you might not need care now or in the future, you are almost certainly going to be connected to it because of those around you.

Connecting communities

Social care is also a vital piece of the puzzle that is needed to hold our communities together, making connections to other council services and those provided by local partners. This can help create a network of local support that enables people to be themselves and to fully participate in and contribute to their communities. In the process, this makes those communities more resilient and sustainable; more human.

Links to voluntary, community and social enterprise (VCSE) organisations are particularly important. For instance, the Joint VCSE Review initiated by the Department of Health and Social Care, Public Health England and NHS England notes that:

> "There is wide agreement that community organisations, charities and social enterprises are key to establishing a more community-based health, care and public health system which will help people live well, longer and at home, rather than spending long periods within health and care services. They are particularly vital to groups and communities which experience health inequalities and are currently less well reached and supported.[7]"

5 https://www.local.gov.uk/about/campaigns/towards-sustainable-adult-social-care-and-support-system
6 https://www.adass.org.uk/media/4475/distinctive-valued-personal-adass-march-2015-1.pdf
7 https://voluntarycommunitysocialenterprisereview.files.wordpress.com/2018/05/vcse-review-action-plan-may-2018.pdf

"People like me, who were professionals and could make a contribution with the right support, are being cut out of the workforce" Josie's story

The Review pointed to two key system shifts. First, towards greater personalised care and the building of wellbeing and resilience through co-designing health and care systems with citizens and communities. And second, a bigger and more strategically resourced role for VCSE organisations "which thinks and acts whole-person, whole-family and whole-community"[8].

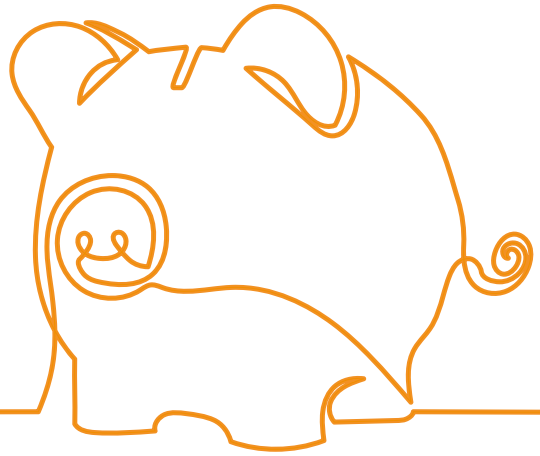
Sustaining our NHS

Social care is also central to the fortunes of our NHS and managing pressures on our hospitals in particular. Care and support, and its links with primary care and public and community health, helps keep numbers at the front door of hospitals down. For those who require time in hospital, that same support in the community helps keep the back door open so people can return home in a safe and timely fashion. Latest statistics for May 2018 show that delays leaving hospital due to social care are down by 39 per cent since July 2017[9]. To put that into perspective, delays due to the NHS are down 13 per cent over the same period.

Supporting our economy and productivity

Finally, the scale of social care is huge. It comprises more than 20,000 organisations and a workforce of more than 1.5 million. Skills for Care estimates that the sector contributes £46 billion annually to the UK economy (£38.5 billion to the English economy)[10] and independent care providers are an integral part of many local economies and a driver of employment and local economic growth. Carers UK estimate that the economic value of the contribution made by unpaid family carers in the United Kingdom is a staggering £132 billion a year, more than annual spending by the NHS[11].

Supporting people's wellbeing has wider benefits for our economy. As the Government's Industrial Strategy notes, "Innovation in age-related products and services can make a significant difference to UK productivity and individuals' wellbeing"[12].



8 https://voluntarycommunitysocialenterprisereview.files.wordpress.com/2018/05/vcse-review-action-plan-may-2018.pdf
9 https://www.local.gov.uk/about/news/lga-responds-latest-delayed-transfers-care-figures-9
10 https://www.skillsforcare.org.uk/About/News/News-Archive/Adult-social-care-employers-contribute-46-billion-to-the-UK-economy.aspx
11 https://www.carersuk.org/for-professionals/policy/policy-library/valuing-carers-2015
12 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664563/industrial-strategy-white-paper-web-ready-version.pdf

The Strategy's ambition to create "an economy that works for everyone, regardless of age" must recognise the link between good health and greater economic participation – both as workers and consumers. The percentage of people aged 65+ who work has risen to 10.4 per cent from 6.6 per cent since 1992[13] and people aged 65+ contributed or spent £37 billion to the UK hospitality sector in 2015 (27 per cent more than people aged 35-54)[14]. If everyone worked for a year longer, GDP would rise by 1 per cent[15]. More broadly, it is estimated that grandparents now provide up to 40 per cent of childcare, enabling their children to pursue their careers without restriction from prohibitive childcare costs[16].

The focus must not be confined to older people. Demographic trends do not just forecast a growing elderly population but a growing number of working age adults with learning disabilities, mental health problems or long-term conditions who will need adult social care and support for them to lead independent productive and fulfilling lives. Putting the right support in place to help tackle the disability employment gap – the difference between employment rates of disabled (49 per cent) and non-disabled people (80 per cent)[17] – would support working age disabled people into meaningful employment and contribute to local economies. Just as important is supporting people with a mental health condition to remain in, and thrive at, work. The 2016 Stevenson and Farmer review noted that, "300,000 people with a long-term mental health problem lose their jobs each year". The review found that, "The cost of poor mental to government is between £24 billion and £27 billion" (costs associated with providing benefits, loss of tax revenue and costs to the NHS) and that, "the cost of poor mental health to the economy as whole is…between £74 billion and £99 billion a year"[18]. Neither should we just consider the national picture. Locally, and particularly in areas with lower employment rates and lower economic output, the care sector is a major and vital employer of local people who, in turn, support the local economy.

13 https://www.local.gov.uk/sites/default/files/documents/22.11%20Healthy%20Ageing_web_0.pdf

14 https://www.barclayscorporate.com/content/dam/corppublic/corporate/Documents/AgeingPopulation/Ageing-Population-North-West.pdf

15 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/32172/10-1047-default-retirement-age-consultation.pdf

16 https://www.local.gov.uk/sites/default/files/documents/22.11%20Healthy%20Ageing_web_0.pdf

17 https://www.citizensadvice.org.uk/Global/CitizensAdvice/Families%20Publications/Halvingthedisabilityemploymentgap.pdf

18 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/658145/thriving-at-work-stevenson-farmer-review.pdf

A locally led service

When it comes to the importance of social care being a local service, expert contributors to our think piece series were equally clear that 'local' matters. At the heart of this principle lies the greatest strength of local government: its democratic accountability to the people it serves. As all communities are different and require a unique arrangement of services, the importance of local accountability cannot be overstated.

Recent LGA polling on resident satisfaction shows that councils are the most trusted form of government to make local decisions about services in a local area, selected by 72 per cent of respondents. Just 17 per cent of respondents selected national government. Similarly, local councillors were selected by 68 per cent of respondents as the individuals most trusted to make decisions about local services. By comparison, 13 per cent of respondents selected MPs and just 7 per cent selected government ministers[19].

CONSULTATION QUESTIONS:

2. In what ways, if any, is adult social care and support important?

3. How important or not do you think it is that decisions about adult social care and support are made at a local level?

Social care innovation and improvement

Despite a challenging financial environment, adult social care and linked services have worked hard to continue to deliver, improving people's lives in a number of ways.

Prioritising care and support: Between 2010 and 2017, adult social care has had to make savings and reductions worth £6 billion as part of wider council efforts to balance the books. But the service continues to be protected relative to other services. The latest ADASS budget survey shows that adult social care accounts for a growing total of councils' overall budgets, up from 36.9 per cent in 2017/18 to 37.8 per cent in 2018/19[20]. As a result, by 2019/20, 38p of every £1 of council tax will go towards funding adult social care.

Innovating: Councils are committed to innovation to help reduce costs while maintaining or improving services to the public. This has included changing the way that demand is managed, more effectively using the capacity in communities to help find new care solutions, and working more closely with partners in the NHS to reduce pressures in the care and health system. Innovative approaches can be found in all parts of the country.

19 https://local.gov.uk/sites/default/files/documents/research%20-%20Resident%20Satisfaction%20Polling%20Round%2020%20-%2025%20july%202018.pdf

20 https://www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf

Intervening early and preventing needs: Investing in prevention has clear benefits for people and reduces costs to the wider care and health system. There is a great deal of work across the country to help people avoid unnecessary hospital admission and support to increase people's independence.

Performing: Even in the deeply challenging financial environment in which the wider social care sector has operated over the last few years, there are many instances of performance having been maintained or improved. This includes performance on satisfaction levels, adults with a learning disability living in their own home or with family and the proportion of people using services who say they feel safe and secure.

A range of case studies demonstrating the work of councils and their partners on the above areas can be found at Annex A. These illustrate the significant improvements and innovations which the social care sector has delivered, despite the most challenging circumstances. It is a sector worth investing in.

The role of digital and technology

We increasingly live in a connected and digital society. Of course, digital and care-related technology is not on its own the solution to addressing our adult social care or public health related challenges and it is not a replacement for person-centred care and support.

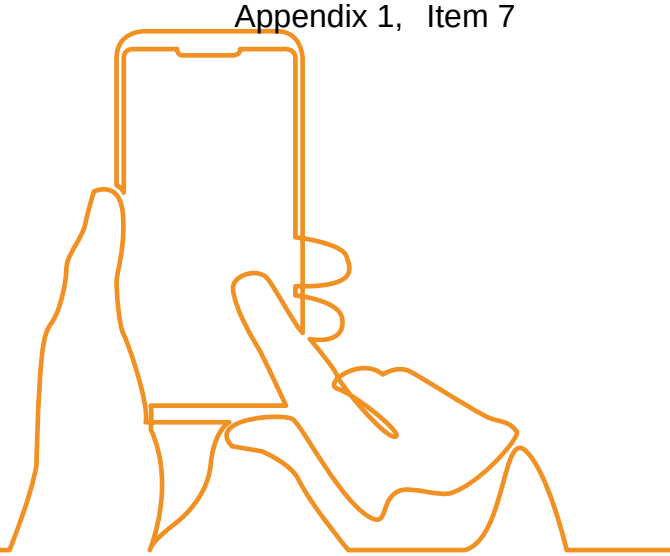
However, better use of data in adult social care offers the potential for more preventative and personalised approaches to care to be established, and emerging technologies offer the potential for new business models to flourish amongst providers of care whether they be large or micro care providers[21]. Councils have an important role to play in shaping their care market and areas such as Liverpool and Luton are collaborating with care providers to support innovation.

Digital approaches are enabling valuable time of our workforce to be freed up, allowing them to spend more time with those they are supporting whilst at the same time improving the quality of care.

It has the potential not only to enable staff to more effectively communicate with one another (helping to address the quarter of care providers who say the quality of information they receive on discharge is not sufficient[22]) but also reduce the chances that people have to tell their story multiple times by joining up information from organisations. Progress has been made but still

21 See Industrial Strategy White Paper – Healthy Ageing Grand Challenge

22 Care Quality Commission, Beyond Barriers 2018



only three in 10 councils say that they have the information they need from health partners[23].

Technology has the potential to help people live more independently for longer, supporting the focus on prevention. Many of us are increasingly adopting smart technologies around the home and increasingly homes are being designed in a way that can both meet but also adapt to our everyday needs.

Understandably, people's expectations are increasing. People want to be able to make quicker and more informed decisions about their care choices which means providing the right information at the time they need it.

At the same time people want to be more in control. This might include giving people more opportunities to easily request the support they need and manage their personal budgets (such as in Harrow) or allow some of the worry to be taken out of caring by giving much more useful and timely information to those in a caring role.

Of course, digital is not right in every situation and where it is introduced it needs to remain person-focused, building trust with individuals. This means starting by understanding the aspirations and needs of individuals and co-designing approaches with them. Councils such as Salford are working with local organisations to support the city's most vulnerable.

The 2016 LGA publication 'Transforming social care through the use of information and technology' provides evidence from across the country of how both social care and public health are designing approaches that incorporate aspects of digital and data – not only saving money but importantly delivering better outcomes for individuals, carers and the workforce.

But as our green paper demonstrates there is still a significant way to go and only with much needed sustainable investment alongside local leadership can existing good practice be extended. Our LGA innovation programme in social care[24], funded by NHS Digital, demonstrates examples of where councils are co-designing approaches that use digital and data. However, these small-scale funding initiatives whilst helpful are not sufficient. The national priority being given to data and technology needs to be re-balanced and show a greater commitment to support local but scalable innovation in adult social care helping to address the systemic challenges that the sector is currently experiencing.

23 LGA Digital Self-Assessment with councils 2017

24 www.local.gov.uk/scdip

"What is important is that we have a system that makes sure people get looked after in the way they want because that's the very least we all deserve"

Glyn and Kristin's story

The need for continuous improvement

Whilst there is a huge amount of impressive work going on across the country, there is much more we can do to improve, even within existing funding arrangements. Polling suggests that the public remain concerned about achieving a consistent standard of care both in social care and the NHS, and preventing a 'postcode lottery'. Variation in itself is not a bad thing; diversity of care and support is needed to address the diversity of different communities, and it would be wholly wrong to suggest that every area should have exactly the same set of priorities or range of services for their local population. But nobody wants to see radically different experiences of, or access to, services based solely on where you live rather than on what you need and want. This is one of the reasons that the Care Act introduced a national eligibility framework, to ensure that people across the country are entitled to care on broadly consistent criteria.

There is little evidence that running services nationally makes them more uniform than services planned and delivered locally. The idea that more national systems and approaches would necessarily help eradicate unwanted local variation is flawed: it could exacerbate inequalities which only a highly localised response can address. As is any notion that local government is more variable than other public services. Within the NHS for instance, there is still very significant variation in access, quality and outcomes, including delayed transfers of care attributable to the NHS, Continuing Healthcare eligibility, the rate of patient safety incidents and the availability of IVF treatments. More broadly, variability is not unique to the public sector and is instead an inevitable feature of life. The accessibility and availability of banks, shops, transport connections and restaurants is part and parcel of what makes every area different.

We need a system in which variation reflects positive choices in local areas to reflect local needs and wishes, and to build communities that are inclusive, cohesive and promote the life chances of everyone within them. Councils' bespoke solutions to local challenges also allow greater space for innovation and improvement to flourish, which is harder to achieve with national-level services. Local investment decisions help change the way things are done on the ground, creating services and partnerships – particularly with the voluntary sector – that benefit our communities. It is no coincidence that many national programmes start from best practice from within local government.

The Prime Minister rightly wants best practice to be shared[25]. And councils are keen to embrace learning through sector-led improvement, and have welcomed the findings of the CQC reviews of health and care systems. However it would be wrong to presume that a mandatory national inspection programme of council commissioning would necessarily improve matters. Local government has worked with Government to develop its own sector-led improvement approach and it has been shown to be more cost effective than national inspection. The National Audit Office estimates that the cost of the previous top down inspection regime was in excess of £2 billion annually[26] whilst the LGA receives just 1 per cent of that to facilitate its wider improvement support in councils. Large

25 https://www.parliament.uk/documents/commons-committees/liaison/Prime-Minister-oral-evidence-session-transcript-20-12-2017.pdf

26 https://www.webarchive.org.uk/wayback/archive/20070428120000/http:/www.lyonsinquiry.org.uk/submissions/20060308%20National%20Audit%20Office%20Response%20to%20Interim%20Report.pdf

parts of the previous inspection regime were abolished by Government in 2010 due to the expense. Sector-led support also delivers good results, with 95 per cent of chief executives and 96 per cent of leaders saying that it has had a positive impact on their authority[27].

We recognise that the public expect, and have a right to, a consistent level of access, quality and effectiveness of care and support. Councils, working alongside national and local partners, are identifying where unacceptable variation exists and taking steps to tackle it. Local government is committed to working with national government to build on this work, and the sector-led improvement approach that underpins it, to ensure that any new funding for social care is used effectively. Examples of this work are set out below.

Working together for a system-wide focus

- Local government political and professional leadership increasingly recognises that significant improvements to people's wellbeing cannot be made by just focusing on their part of the health and care system. The recent focus on delayed transfers of care (DTOC) attributable to adult social care is a case in point. Research undertaken for the LGA by Newton Europe[28] into DTOCs attributable to social care in 17 health economies found that focusing on just one part of the system risks either ignoring underlying causes of the blockage or simply shifting pressure elsewhere. The work found that the best way to help patients through discharge is to ensure the focus on their longer term recovery. DTOC is a symptom of system malfunction, not of itself a root cause. Put the patient first and the rest will follow.
- The CQC local system reviews made a similar finding in relation to managing the flow of older people from community settings into hospital and back again. It found that the key driver to overcoming barriers to effective joined up working was local leaders sharing a clear vision to provide a shared purpose for people and organisations across the local health and social care system. Fragmented and separated systems for local government and social care get in the way of person-centred and place-based working. In particular, separate financial frameworks, performance management regimes, workforce planning and regulatory frameworks for the NHS and local government make it difficult to work together. We would welcome the continuation of these cross-sector reviews alongside a sector-led improvement approach to adult social care.

27 http://lga.moderngov.co.uk/documents/s17081/LGA%20Perceptions%20Survey%202017-18.pdf

28 https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/resources/emerging-practice

CONSULTATION QUESTION:

4. What evidence or examples can you provide, if any, that demonstrate improvement and innovation in adult social care and support in recent years in local areas?

System leadership

- Some health and wellbeing boards (HWBs) are the driving force for transforming care and support in local communities. They bring together political, health and community leaders to agree a vision and a shared approach to health and wellbeing which addresses the challenges facing their care and health systems. But others are not providing clear leadership and direction. We recognise that if they are to maintain their status as leaders of place, all health and wellbeing boards need to be effective. A key strand of our improvement work focuses on strengthening HWBs in this respect, equipping council leaders with the tools they need to work alongside clinical and community counterparts.

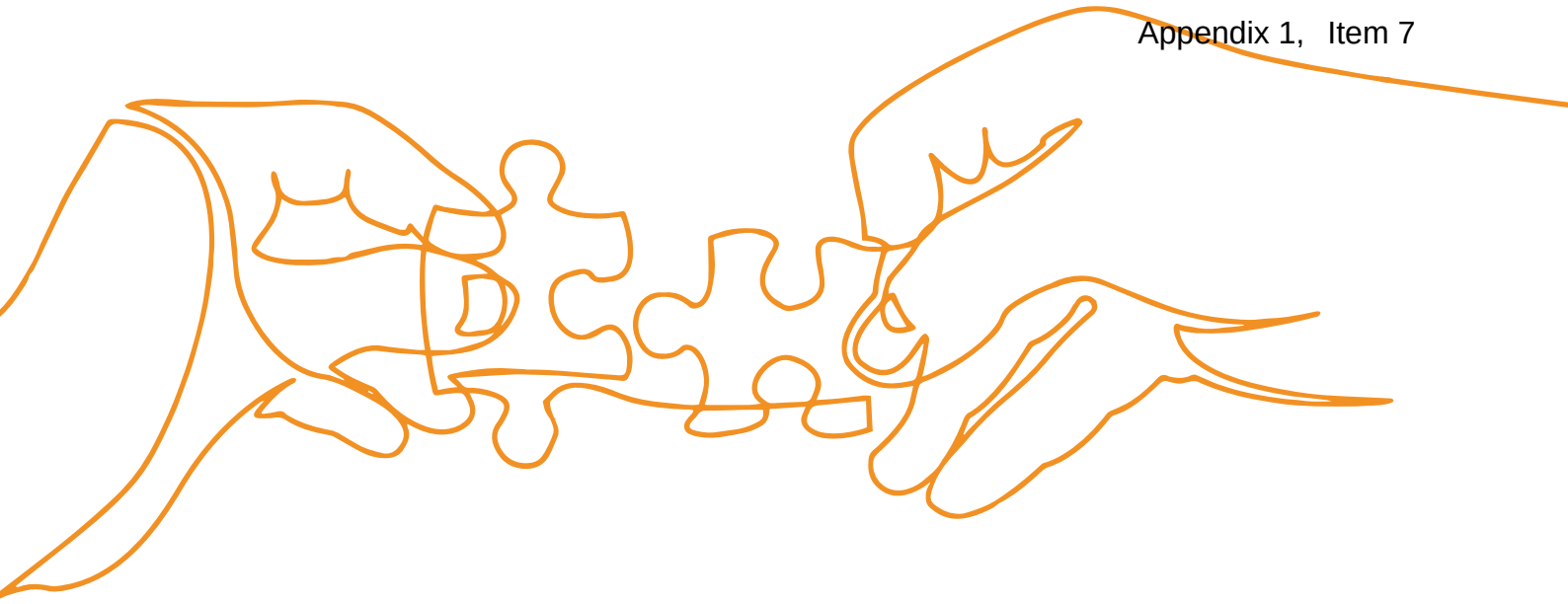
Integrated commissioning

- Councils recognise the importance of strong commissioning and are taking steps to ensure this drives improvement. Building on our framework for commissioning for better outcomes in social care, we are working with councils to focus on Integrated Commissioning for Better Outcomes[29]. A future model of social care will need to continue to develop and strengthen integrated commissioning.

Shaping the local care market

- Market Position Statements (MPS) are a requirement of the Care Act and encourage commissioners, people who use services, unpaid carers and providers to come together to consider what care and support services are needed in an area, why, and how they might be delivered. Councils recognise the value of MPSs and the need to ensure their robustness and quality.
- The LGA is working with councils and providers to develop the next generation of MPSs that focus much more on: the services needed in a local area; how they can support people to stay out of hospital and live independently at home; support to providers to recruit, retain and develop the care workforce.

29 https://www.local.gov.uk/icbo



Improving system-wide performance and effectiveness

- All of our work on systems has the primary objective of supporting councils to work with all relevant local partners to help keep people out of hospital and, if they do need inpatient care, return them to their communities and full independence as far as possible.
- An example is the Transforming Care Partnership, which helps ensure that more people with complex learning disabilities are moving from secure Assessment and Treatment Units to better placements in their own community near family and friends.

Data sharing

- Councils increasingly recognise the need for sound data sharing across health, social care and providers to deliver person-centred care and the role of technology to improve integration, efficiency and commissioning.

Support to challenged areas

- Some areas face a particularly challenging financial environment and require expert support to steer their way through to steadier and more stable times. We have worked with 20 such areas to address real and present financial problems. This is our fastest growing area of support.
- Other areas need support to deliver efficiencies, particularly in learning disability and mental health services, and a range of work is being taken forward to help councils to manage demand.
- As financial circumstances become ever strained, more areas are identifying the need to be better prepared on contingency planning in the event of large scale provider failure. Most councils are experiencing contract hand backs, but the risk of large scale failure is increasing as evidenced by the changing numbers in CQC's market oversight regime.

Managing risk

- More generally, councils recognise the need to be smarter and more nimble at managing risk. All councils have used our risk tool in some form to aid their understanding of risk in key areas including leadership and governance, performance, quality, resources, workforce and delivering national priorities.

The funding challenge and its consequences

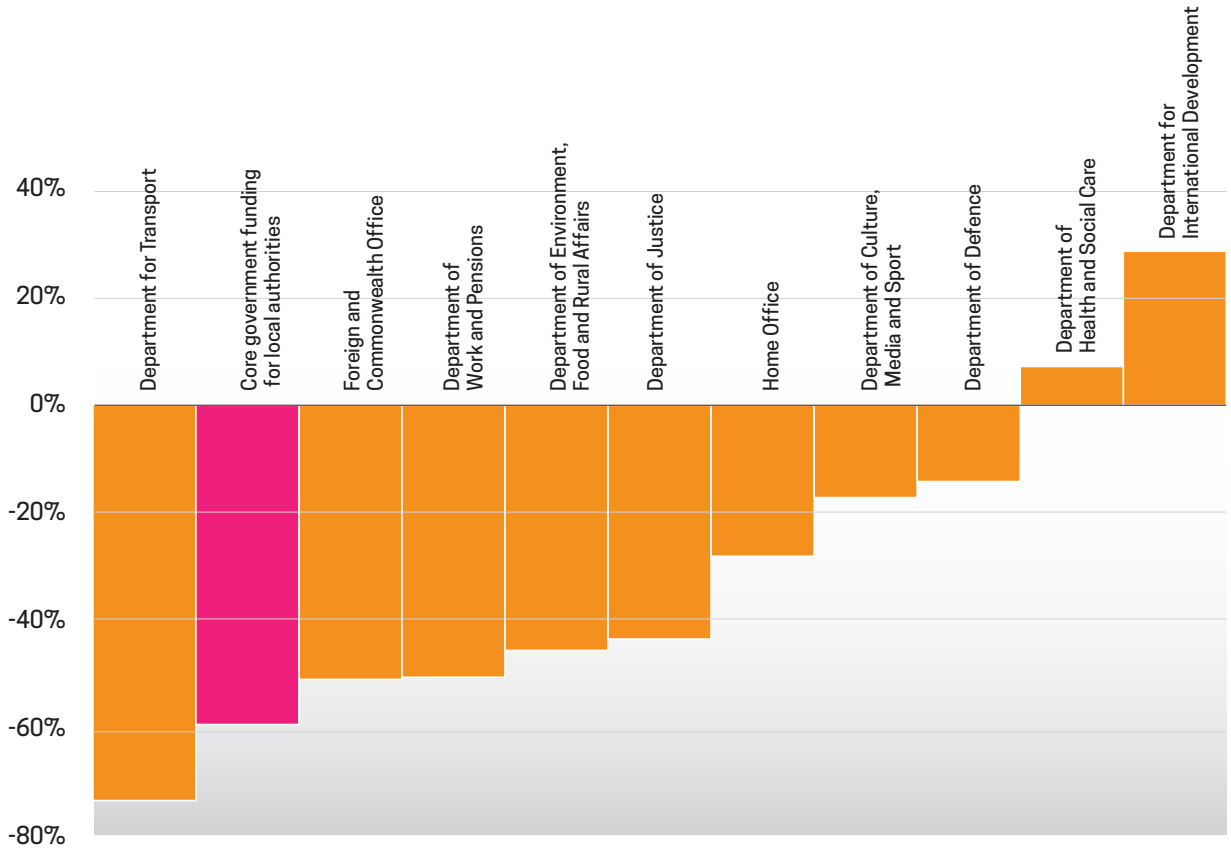
Local government and the NHS: systems under pressure

The full potential of local government's contribution to wellbeing is struggling to be realised following years of austerity. Councils are not unique in having had to respond to the impact of austerity and, like many organisations, have met the challenge head on. But the scale of the challenge they have faced, and the savings and efficiencies they have made, is significant and cannot be overplayed.

Since 2010, successive governments have cut 60p out of every £1 of national funding for local council services, saving nearly £16 billion a year by 2020. Local government has been cut considerably deeper than many other areas of the public sector and others have seen increases in their budgets, as the chart below shows.

Councils have responded on multiple fronts. They have pursued an efficiency agenda rigorously. They are sharing staff, buildings and delivering services together. Some have merged, some have had to use money that was set aside for major investments to support day-to-day services. Wherever they can, councils have looked at different ways of delivering services and support to citizens, or taken action to reduce

REAL TERMS CHANGE TO REVENUE FUNDING 2010-20
PERCENTAGES



"I am only too aware that every minute I spend with paramedics is taking this costly service away from someone else who needs it, but I am left with no choice" Vicki and Keegan's story

demand rather than making cuts. But against the scale of the reduction outlined, these efforts can only go so far. As the Public Accounts Committee has noted, "The harsh reality is that more and more local authorities are now showing signs of financial stress"[30]. Today, more councils are struggling to balance their books and some are considering whether they have the funding to even deliver their statutory requirements. Put simply, councils no longer have the resources to support people in their communities[31].

The local government funding position has serious consequences for wellbeing. It constrains adult social care which, in turn, constrains the voluntary sector and care providers. This is happening now and impacting on people's quality of life today. The response has been to protect social care relative to other council services. But those other services are crucial to support people's wellbeing, such as bus services, libraries and road maintenance. In this way, sorting out the long-term funding of adult social care therefore goes hand-in-hand with helping to sort out the long-term funding of local government. And that can only help improve people's wellbeing.

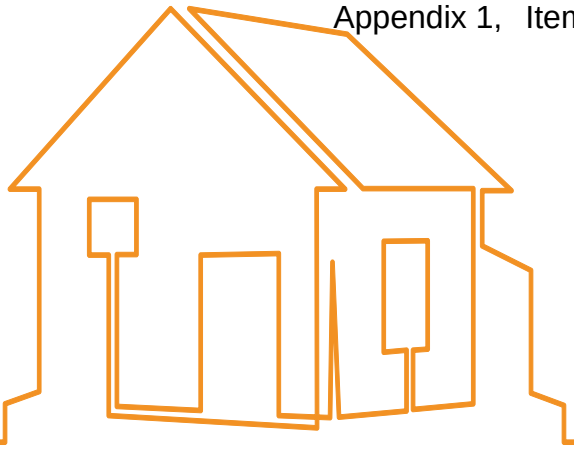
The NHS is also struggling. A report by NHS Providers shows that community health services are also under pressure. More than half of community trusts surveyed (52 per cent) for the report believed funding had fallen this financial year and 82 per cent were worried that community health services would not receive the investment needed to realise the ambitions of the Five Year Forward View[32].

It is a similar picture with GPs with the King's Fund noting that:

> "General practice is in crisis. Workload has increased substantially in recent years and has not been matched by growth in either funding or in workforce…Funding for primary care as share of the NHS overall budget fell every year in our five year study period.[33]"

As social, community health and primary care face growing pressure, wellbeing deteriorates. As a result, people increasingly seek to have their needs met by turning to the part of our public sector which has arguably been protected from the full force of austerity: hospitals. But targeting investment primarily at the acute sector represents poor investment of public money. And more importantly, it is a poor outcome for most people needing care and support. The argument is bigger than simply saying we spend too much on hospitals. It is about arguing for investment for prevention across the wider system – social care, public health, the third sector and parts of the NHS – as part of a truly system-wide approach to embedding prevention and early intervention within our communities and in everything we do. Good investment and good outcomes for people requires a focus on these communities, ensuring people have the care and support (in the broadest sense) they need to live a good life – to be well, independent, living at home for as long as possible and contributing to family and community life.

30 https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/970/970.pdf
31 For further information visit: https://www.local.gov.uk/sites/default/files/documents/Moving%20the%20conversation%20on.pdf
32 http://nhsproviders.org/state-of-the-provider-sector-05-18
33 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf



Adult social care funding

As with local government overall, adult social care funding is at its absolute limit, threatening the great progress that has been made in challenging circumstances. Innovation, prevention and performance may be some of the hallmarks of the last few years as social care has sought to insulate itself from the full impact of austerity. But looking ahead, the scope to continue in this way is greatly reduced.

New research by the LGA shows that local government overall faces a funding gap of £7.8 billion by 2025, just to sustain current – and much reduced – levels of service. This includes, within adult social care, an immediate and annually recurring market provider gap of £1.44 billion; the difference between the estimated costs of delivering care and what councils pay. As demography, inflation and National Living Wage pressures build in subsequent years, the adult social care gap rises to £3.56 billion by 2025[34]. And again, this is purely to stand still. To put this in perspective, this is more than five times the amount spent annually on councils' park services, and close to the total cost of councils' waste management for a year (£3.6 billion). The short-term funding gap must be closed as an urgent priority and as an initial step in securing the sustainability of care and support.

Governments' response to the challenge of adult social care funding in recent years has been short-term and incremental in nature. One-off grants, the council tax precept for social care and increases in improved Better Care Fund funding have been helpful. But each mechanism has its limitations and they have not been sufficient to deal with all short-term pressures, let alone address the issue of longer-term sustainability. They also cease in 2019/20 with no clarity from 2020 onwards, which makes even short- and medium-term planning extremely difficult.

Furthermore, the major Government narrative and focus of attention has been on services to support older people, largely overlooking the fact that much of the growth in cost pressures comes from the increasing needs of working age adults. As the ADASS budget survey[35] shows, services for working age adults now account for 58 per cent of the demographic pressure on social care budgets, including 39 per cent relating to services for people with a learning disability. The demographic pressure relating to older people accounts for 42 per cent of total pressure. This might explain why the proportion of directors most worried about the financial pressures relating to services for working age adults has doubled since last year to 32 per cent and compares to only 12 per cent who are most worried about services for older people.

34 https://www.local.gov.uk/sites/default/files/documents/Technical%20Annex%20%281%29.pdf
35 https://www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf

The council tax precept is not a sustainable solution. First, it shifts the burden of tackling a clear national crisis on to councils and their residents – and this after years of councils being encouraged to keep council tax as low as possible, or frozen. Second, the value of the precept varies greatly based on the strength of a council's tax base. Areas facing the greatest demand for services are those that are able to raise the least amount of money through the precept.

Already in 2017/18, the adult social care precept was worth 3.8p of every £1 of council tax raised in England. If all councils with social care responsibility used the precept flexibility and the 2.99 per cent core increase in 2018/19 and 2019/20, this would rise to 6.5p of every £1 of council tax. By the same point, councils could be spending as much as 38p of every £1 of council tax on adult social care, up from just over 28p of every pound in 2010/11.

Improved Better Care Fund resources are also problematic. As explored further below, this funding has become subject to an increasing and concerning degree of oversight and influence from both government and the NHS nationally. The funding also stops at the end of 2019/20.

The consequences of underfunding in adult social care

The consequences of this immediate and medium-term funding gap will likely include a deepening of the consequences seen to date in a range of areas.

Quality: Latest information from the Care Quality Commission shows a broadly encouraging picture on quality, with more than four fifths of adult social care services in England rated as 'good' (79 per cent) or 'outstanding' (2 per cent) following inspection. However, a more worrying trend is emerging amongst services that have been re-inspected. For those services previously rated 'good', 76 per cent saw no change to their rating, but 18 per cent dropped to 'requires improvement' and 3 per cent dropped to 'inadequate'. Amongst those services previously rated 'outstanding', 64 per cent saw no change to their rating, 19 per cent dropped to 'good', 14 per cent dropped to 'requires improvement' and 3 per cent dropped to 'inadequate'. Improving quality is one thing, sustaining it is clearly another and it is becoming harder to achieve[36].

Provider market stability: providers of social care are an absolutely vital part of the social care landscape, delivering practical care services with an essential human touch both to self-funders who pay for their own care and those who are funded by their council. But the provider funding gap outlined above, coupled

36 https://www.local.gov.uk/sites/default/files/documents/Securing%20the%20long-term%20sustainability%20of%20adult%20social%20care%20%E2%80%93%20Quality%20-%20Andrea%20Sutcliffe%20CBE.pptx_.pdf

"I don't feel like I'm living, just existing"
Josie's story

with new pressures (such as the potential future uncertainty on liabilities for 'sleep in' care) is putting providers under impossible pressure. In the last six months, this has resulted in providers ceasing trading across home and residential care in more than 100 council areas, impacting more than 5,300 people. It has also resulted in providers handing back contracts to more than 60 councils, impacting just under 3,000 people[37]. Providers make these decisions reluctantly, especially having worked with local communities and individuals over many years. These are difficult decisions that are made when the full costs of care cannot be covered. Some providers are having to reduce the amount of their capacity used by local authorities because it is not profitable. They may seek to increase their income from self funders or others, such as NHS commissioners. The impact is a loss of capacity for local authorities and a knock-on impact on their customers and the NHS.

Unmet and under-met need: under the Care Act, councils are required to follow a national minimum threshold for eligibility. This means that there is a single and consistent framework for determining whether a person's needs are eligible for public support. The level at which this is currently set, combined with the pressures on social care described above, has arguably been partly responsible for an increase in unmet and under-met need.

Age UK estimates[38] that there are 1.4 million older people who do not receive the help they need. This includes 164,217 people who need help with three or more essential daily activities (such as washing, dressing and going to the toilet) and who receive no help at all from either paid services or family and friends[39]. As a purely indicative figure, the LGA estimates that if councils were to support this group of 164,217 older people, £2.4 billion additional funding would be needed[40]. Looking to working age adults, and again purely as an indicative figure using estimates based on broad assumptions set out below, the LGA estimates that addressing unmet need amongst the 18-64 population would require an additional £1.2 billion[41]. Unpaid carers also experience unmet need. New research by Carers UK shows that one in seven carers (or those they support) received less care or support in the previous year[42].

Unmet (and under-met) need is bad for people and can lead to the worsening of their conditions, and the costs involved in meeting them. But more broadly, it is bad for our economy and can lead to a huge loss of economic input. As we set out above, supporting people's wellbeing plays an important role in helping

37 https://www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf

38 https://www.ageuk.org.uk/latest-press/articles/july-2018/new-analysis-shows-number-of-older-people-with-unmet-care-needs-soars-to-record-high/

39 https://www.ageuk.org.uk/latest-news/articles/2018/july/1.4-million-older-people-arent-getting-the-care-and-support-they-need--a-staggering-increase-of-almost-20-in-just-two-years/

40 Our estimate of the cost uses Age UK figures as a starting point. We take their figure of 164,217 – the number of older people who receive no support with three or more essential daily activities – and assume support for those people based on the profile of existing support for older people in terms of home care and residential care. We then apply unit costs: for home care we cost 1 hour per day; for residential we cost a year of residential care.

41 We apply the same method used for estimating the cost of meeting unmet need amongst older people. However, as we do not have a starting number (equivalent to the Age UK figure of 164,217) we link to the number of working age adults currently receiving services. The number of working age adults supported is roughly 40 per cent of the number of older people supported so we apply that percentage to the Age UK figure and apply working age adult unit costs for home and residential care.

42 https://www.carersuk.org/images/Downloads/SoC2018/State-of-Caring-report-2018.pdf

people to be employed, to be active consumers and to be a support for relatives juggling work and family commitments.

Carers: our care system could not survive without the invaluable input provided by unpaid family carers. But as pressures mount on social care, carers shoulder an increasing strain and this impacts on their own physical and mental wellbeing. New research by Carers UK shows that 72 per cent of carers in England have suffered mental ill health (such as stress and depression) as a result of caring and 61 per cent had suffered physical ill health. A clear majority of carers believe their mental (57 per cent) and physical (58 per cent) health will get worse in the next two years[43]. When an unpaid caring role breaks down, everyone suffers and costs rise. The research by Carers UK also shows that one fifth of carers had not received a carer's assessment in the last year[44]. The LGA estimates that it would cost an additional £150 million to provide those assessments.

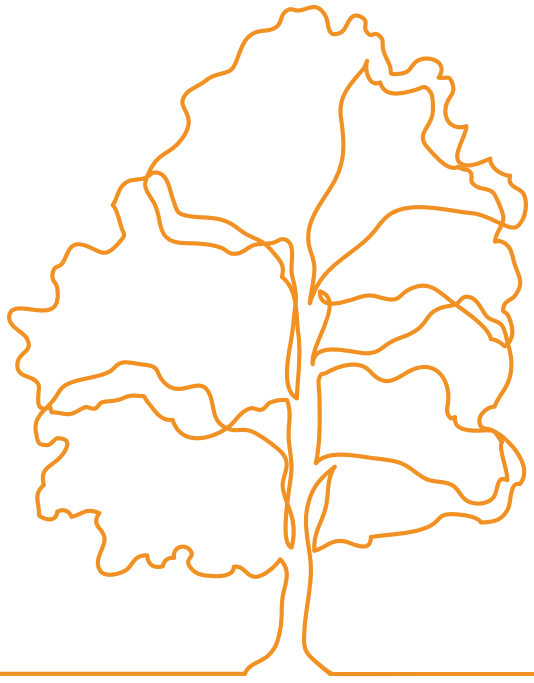
Workforce: like unpaid carers, the social care workforce is at the core of our care and support system. Its scale is significant.

> "Adult social care is a growing sector that, in 2016, had around 20,300 organisations, 40,400 care providing locations and a workforce of around 1.58 million jobs. The number of full-time equivalent jobs was estimated at 1.11 million and the number of people working in adult social care was estimated at 1.45 million[45]."

43 https://www.carersweek.org/images/Resources/CW18_Research_Report.pdf

44 https://www.carersuk.org/images/Downloads/SoC2018/State-of-Caring-report-2018.pdf

45 https://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/2State-of-the-adult-social-care-sector-and-workforce-2017.pdf



But it too is under significant pressure. Skills for Care estimates that the staff turnover rate of directly employed staff working in social care was 27.8 per cent in 2016/17, approximately 350,000 leavers during the year[46]. This compares to average labour turnover across the economy of 15 per cent, and 13.4 per cent across local government direct employment.

The National Audit Office has shown that the "growth in the number of jobs has fallen behind growth in demand for care" and that, as we set out above, "The failure of formal care to meet this increased demand may have contributed to the growth in individuals' care needs not being met"[47]. This trend looks set to continue. Skills for Care forecasts show that if the social care workforce grows proportionally to the increase in the number of older people aged 75 and over, an increase of 44 per cent (700,000 jobs) will be needed[48].

This will be challenging. Directors of adult services believe increasing salaries for care workers is the most important factor in recruitment and retention, which will only increase pressures on budgets. Furthermore, pay rises of 29 per cent over the next three years for the lowest paid NHS staff across England will make the challenge even greater. Directors believe a similar pay rise for social care staff would cost an additional £3 billion a year[49]. But it is not simply a matter of money. As the National Audit Office has pointed out, care work – particularly lower level roles – suffers from negative perceptions and "is viewed by the public as low skilled and offering limited opportunities for career progression[50]"

In terms of the workforce directly employed by councils, social workers and occupational therapists are key regulated social care professionals in local authority social care departments responsible for ensuring the protection of people's human rights and promoting safety, inclusion and citizenship outcomes. Social work has one of the highest vacancy rates at 10.8 per cent and a staff turnover rate of 15.6 per cent, and only a third of social work graduates enter adult social care.

Escalating problems: more generally, the underfunding of social care and support results in people's wellbeing and outcomes deteriorating as their needs rise and go unmet. This can lead to increased loneliness or the worsening of long-term conditions and results in further demand pressures on the NHS.

CONSULTATION QUESTIONS:

5. What evidence or examples can you provide, if any, that demonstrate the funding challenges in adult social care and support in recent years in local areas?

6. What, if anything, has been the impact of funding challenges on local government's efforts to improve adult social care?

7. What, if anything, are you most concerned about if adult social care and support continues to be underfunded?

46 https://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/2State-of-the-adult-social-care-sector-and-workforce-2017.pdf

47 https://www.nao.org.uk/wp-content/uploads/2018/02/The-adult-social-care-workforce-in-England.pdf

48 https://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/2State-of-the-adult-social-care-sector-and-workforce-2017.pdf

49 https://www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf

50 https://www.nao.org.uk/wp-content/uploads/2018/02/The-adult-social-care-workforce-in-England.pdf

"Government has already done two of the three jobs we need it to do on social care. It has put in place an excellent piece of legislation – the Care Act – that could provide the right enabling framework for a generation. It has also put in place a trusted inspection system with public confidence. Its third task is to properly fund the system and that should be the primary focus of the green paper"

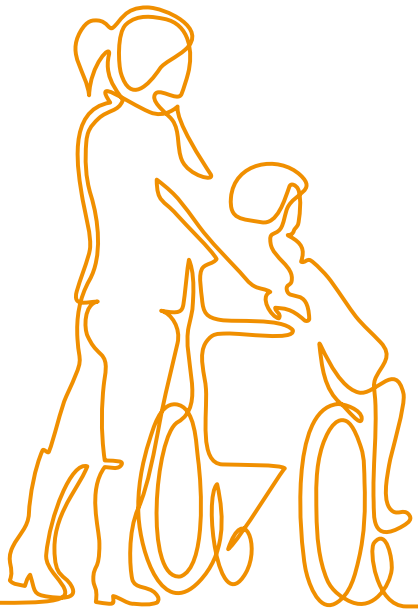
Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership

LGA think piece series, 2018

The Care Act: a legal foundation for care and support

Social care has already been reformed. Between July 2012 and April 2015, the wider social care sector – people with experience of using services, local government, the NHS, providers, the community, voluntary and social enterprise sector, think tanks, academics and the public – came together with Government to help shape a landmark piece of legislation and prepare for its implementation: the 2014 Care Act. This was a model for how laws should be made; collaboratively, with the voices of those who use services front and centre, and with our national politicians and government in genuine listening mode. It is not perfect, no legislation is. But it is close.

It puts people's wellbeing – broadly defined – at the heart of the Act and stresses the importance of preventing or delaying the development of care needs. It makes a clear link to integration with health in achieving both wellbeing and prevention. It promotes the development of a local provider market offering diverse and quality services for both self-funders and publicly-funded care. It puts unpaid carers on a par with those they care for and embeds person-centred care and personalised approaches to care through the care planning process. It promotes personal budgets and direct payments in order to give people choice and control over their care.



However, in spite of a deep commitment to the legislation, councils are increasingly struggling to even meet the 'letter' of the law. In a 2018 survey of adult services directors, just 34 per cent stated that they were 'fully confident' in meeting all of their statutory duties in 2018/19. The figure dropped to one in ten in 2019/20, with no director 'fully confident' of meeting all statutory duties in 2020/2151. We can and must do better.

Implementing Part II of the Care Act

Despite widespread support for the legislation, the Care Act has not yet been fully implemented, with the Part II reforms to introduce a cap on the amount people might have to pay and an extension to the financial means test limits still waiting to be enacted, partly due to the lack of funding for the system as a whole. The LGA supported the decision, arguing that the funding earmarked for a cap should be used to support the existing social care system before adding new duties and reforms on top of it. Full implementation of the 'Dilnot Cap' as set out in the Care Act is one of the reform options considered in the next section.

CONSULTATION QUESTIONS:

8. Do you agree or disagree that the Care Act 2014 remains fit for purpose?

9. What, if any, do you believe are the main barriers to fully implementing the Care Act 2014?

51 https://www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf

4. The options for change

"There's a great deal for us to be worried about. The good news is that there's widespread agreement about an urgent need for action. There's political consensus that something must be done, but the question is what?"

Ben Page, Chief Executive and Anna Quigley, Director of Health Research, Ipsos MORI
LGA think piece series, 2018

Key points:

- Social care is becoming a greater public priority
- The public and politicians (local and national) support greater funding for social care
- People find the social care system complex and confusing, it is hard to understand, particularly for those facing the immediate pressures of requiring care and having to engage with a system they have never encountered before
- People worry about the costs of social care but are not making preparation for them and the rules are not clear
- Although it is hard to define, people want a greater sense of fairness within social care
- There are a number of options for making social care better
- Making these changes will require more funding. There are different ways of raising this
- Cross-party consensus or cooperation must be sought to secure a workable long-term solution

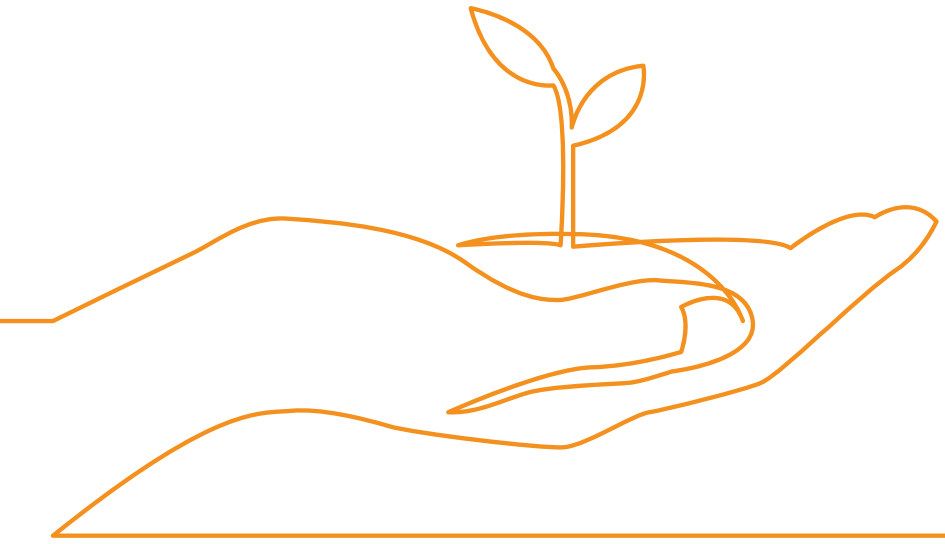
> "The last 20 years have seen at least five independent reviews of social care funding and 12 white papers, green papers and consultations of one kind or another under five governments. It has been a story of delay, dashed hopes and disappointment."
>
> **Richard Humphries,**
> **Senior Fellow, The King's Fund**
> LGA think piece series, 2018

Why is it so hard to change?

Public support

Many of the most significant problems facing social care are primarily driven by a lack of funding, as set out in the previous chapter. Whilst the Care Act remains a widely supported broad legislative framework, more funding is needed to implement it fully. So why has it proved so hard for successive governments to deliver sustainable long-term funding for this crucial service?

The answer lies partly in how the public view social care, which is linked to the fact it is complex and hard to understand. Adult social care and support is not free for everyone. An individual who thinks they need support through adult social services is assessed by their council to identify their care needs and determine whether or not those needs are eligible. If they are, a separate assessment is made of the individual's financial circumstances to determine whether they must contribute to the cost of their care.



"The sad thing is none of us know when or if we will need people to care for us one day so it is vital that everyone is aware of the issues before it is too late to do anything about it" Vicki and Keegan's story

Two recent reports are extremely helpful in understanding the public's concerns: a recent Ipsos MORI report on attitudes to social care funding reform, prepared for the King's Fund and Health Foundation[52]; and a report by public participation charity, Involve, summarising the findings of a 'Citizens' Assembly' they held on behalf of the Health and Social Care Select Committee and the Communities, Housing and Local Government Select Committee[53].

- **A complex and confusing system:** People do not have a detailed understanding of social care services and are unsure about how to access them. Participants with experience of social care said the system was complex, bureaucratic and difficult to navigate. Forty-five per cent of Citizens' Assembly members selected an 'easily accessible' system in their top five principles for a reformed system. Thirty-eight per cent of assembly members put a 'simple clear' system in their top five.
- **Complex and unclear funding arrangements:** Unless they have experience of it, people have limited understanding of how social care funding works. Most people think social care is funded similarly to the NHS, through tax, or that an entitlement based on National Insurance contributions will be available. People with no or limited experience of social care are largely unaware that the system is means tested. Upon learning this, many are "shocked", as they had assumed there is a more generous offer for more people.
- **Transparency and fairness:** People want more transparency – both in terms of the costs of social care (individually and nationally), and in terms of being able to see where funding for social care is being raised and where it is being spent. On fairness, there are a range of views reflecting the different interpretations of what fairness is. These include fairness to older people who have paid taxes all their lives, fairness in protecting people's housing assets, fairness between different generations and fairness based on a person's ability to pay. In respect of private funding, people want an 'asset floor' below which an individual would not have to contribute to their care costs, as well as a 'cap' on the costs of care beyond which an individual would not have to pay. In terms of public funding, there is broad support for increases to Income Tax, a social insurance scheme (a stand-alone compulsory payment as a percentage of income paid by everyone aged 40 and over), and an extension of National Insurance to people working beyond state pension age.

52 https://www.ipsos.com/sites/default/files/ct/publication/documents/2018-06/public-attitudes-social-care-funding-reform-ipsos-mori-2018.pdf

53 https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/citizens-assembly-report.pdf

"Governments can no longer turn a blind eye and say we can't afford it... Government must step up to the plate and be honest with the electorate"
Sandy's story

This detailed work helps to explain the many examples of public polls which show that few people understand social care or how the system is meant to work. For instance, a 2017 Ipsos MORI poll suggested 63 per cent of people believed the NHS provides social care for older people, and 47 per cent believed social care is free at the point of need[54].

It is no surprise, given the difficulty of explaining how the existing system works, that governments have struggled to build the political momentum to make proper and long-term improvements to social care funding, when such changes would require tax increases or cuts to other services to pay for it. But that is no excuse. Public and political opinion is changing, and people who need care and support should not be asked to wait any longer.

That is why we are, as part of this consultation, undertaking further work with the public, building on the excellent studies above, to try and get a clearer sense of which changes are most important and acceptable to them.Read more on our website: **www.futureofadultsocialcare.co.uk**

CONSULTATION QUESTION:

10. Beyond the issue of funding what, if any, are the other key issues which must be resolved to improve the adult social care and support system?

Changing the system for the better

'Standing still' is not an option and never has been. This was certainly the message from the public in the Ipsos MORI and Citizens' Assembly work. And doing so would impact on people's wellbeing and destabilise the care and support system as we have set out above. Building on what we know the public thinks, and thinking about some of the consequences of repeated under-funding of social care that we would like to tackle, the following table summarises a range of key options set out in recent papers for how we might change social care for the better.

This draws on the excellent recent work by Age UK, the Health Foundation and King's Fund[55] and the joint select committee report, 'Long term funding of adult social care'[56]. The Health Foundation/Kings Fund and joint select committee reports compare a range of proposals, along with costings and the table below provides only a summary. For further details please see the links provided.

We have not included the option, set out in the Health Foundation and King's Fund report, of restoring levels of funding to 2009/10 levels. But it is worth noting that they estimate the costs of that at an additional £8 billion in 2021. All of the options below are compared to current funding and, consequently, current levels of access and quality.

54 https://www.slideshare.net/IpsosMORI/the-state-of-the-state-20172018
55 https://www.health.org.uk/sites/health/files/A-fork-in-the-road-Next-steps-for-social-care-funding-reform-0.pdf
56 https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf

The options set out in the table do not, in general, overlap, except that free personal care would mean there was no need for a cap on care costs. They would each help different groups, and are not limited to older people; people with life-long disabilities, or working age adults who acquire a disability, require sustainable funding for care and support in their own right.

In thinking about how we can make the system better there are two broad categories of changes to consider. The first, shaded in the table below, are primarily about making the current system work as intended and relate to implementing statutory duties fully. These would help stabilise the 'here and now', help address the consequences of underfunding as described above, and create a more solid foundation from which to deliver the second, unshaded, options in the table. These are additional proposals for change, which would help address the separate set of concerns identified above that are more to do with notions of fairness, complexity and transparency. They would signal a change to current requirements (although the 'cap and floor' would only require implementation of current legislation, not a new Bill).

The table projects estimated costs in 2024/25 but in considering the long-term future of adult social care we take a longer horizon; the system we build now must be fit for at least the next decade and beyond. In considering the changes we want to make, the question is therefore not simply about preferences for the short- to medium-term, but for the longer-term as well.

	CHANGE	RATIONALE	COST 2017/18	COST 2024/25
Funding existing requirements	**1. Pay providers a fair price for care** (LGA and many others)[1]	The stability of the provider market is central to the provision of high quality care and support that meets people's needs and helps keep people independent at home. Enabling councils to pay a fair price for care (based on cautious industry estimates of what is needed) would help prevent providers ceasing trading and/or handing back contracts, and help to prevent a 'two tier' system between publicly funded care and privately funded care.	£1.44 billion	£1.44 billion
	2. Make sure there is enough money to pay for inflation and the extra people who will need care (LGA and many others)[2]	Without funding for core pressures, unmet need is likely to continue to grow, pressures will build on the provider market and its workforce, and the impact on unpaid carers will continue to increase.		£2.12 billion
	3. Provide care for all older people who need it (based on estimates of unmet need amongst older people by Age UK)[3]	Tackling unmet need amongst people with care needs, would help maintain people's independence and prevent the deterioration of people's conditions and would help allow informal carers to continue their caring role.	£2.4 billion in addition to 1 and 2 above	£3.6 billion, in addition to 1 and 2 above
	4. Provide care for all people of working age who need it (estimates based on broad assumptions set out below)[4]	As above	£1.2 billion, in addition to 1 and 2 above	£1.4 billion, in addition to 1 and 2 above
Reforms to extend entitlements	**5. 'Cap and floor'**	A cap on the maximum costs an individual could face, along with a more generous lower threshold in the financial means test, would protect people from 'catastrophic costs' and more of their asset base. The cost depends entirely on where the cap and floor are set. The Health Foundation and King's Fund modelled costs based on a cap at £75,000 and a floor at £100,000 (as per Conservative proposals at the 2017 General Election)[5]		£4.7 billion[6], in addition to 1 and 2 above
	6. Free personal care (Health Foundation/ King's Fund and Health and Social Care/ Housing, Communities and Local Government select committees)[7]	Free personal care would improve access to social care by removing the current means test and help people to remain independent at home. It would apply to everyone who needed care. Decisions would be required on the level at which the offer applied and what would count as 'personal care'. Accommodation costs – including in residential care – would continue to be the individual's responsibility.		£ 6.4 billion[8], in addition to 1 and 2 above

Please see page 86 for table footnote references

ESTIMATED BREAKDOWN OF 2016/17 GROSS ADULT SOCIAL CARE SPENDING

None of these options removes the need for continued innovation, improvements in efficiency and practice, and joint working with other local services. Indeed, part of the solution may be an innovation and scaling fund to help drive best practice to a wider audience.

Nor should we forget that people exercise responsibility and control over maintaining their own health and wellbeing. They have a right to expect accessible and effective advice, information and support provided by councils, health services and community and voluntary organisations to enable them to make healthy choices and maintain their health and independence. Ultimately, it is the individual's choice to take the steps towards health and wellbeing, though this will become increasingly important over time to help manage the growing pressures of an ageing population living with more long-term conditions. As set out further in Chapter 5 below, councils – with their civil society partners – are ideally placed to support people in this process because of their central role in public health and wider wellbeing services.

CONSULTATION QUESTIONS:

11. Of the above options for changing the system for the better, which do you think are the most urgent to implement now?

12. Of the above options for changing the system for the better, which do you think are the most important to implement for 2024/25?

13. Thinking longer-term, and about the type of changes to the system that the above options would help deliver, which options do you think are most important for the future?

14. Aside from the options given for improving the adult social care and support system in local areas, do you have any other suggestions to add?

15. What is the role of individuals, families and communities in supporting people's wellbeing, in your opinion?

How to pay for these changes

All of the options set out above cost a great deal of money. Despite the fact many people already pay for their own care, even maintaining the current system as it is now will cost more over time due to rising demand and inflation. Current arrangements which pay for publicly-funded adult social care are already complex: mainly resourced through a mix of national government funding (general and specific grants), local government funding (business rates and council tax) and individuals' own contributions (through charges). The chart below sets this out and excludes self-funders, covering just publicly-funded care. The majority of adult social care funding is not ring-fenced.

Increasing public investment in social care will require difficult political choices, especially when they are in addition to the promise of £20 billion a year additional funding for the NHS. But there

is public support for this. Recent public polling consistently demonstrates that the British public are proud of the NHS and want to see funding for it increase, even if that means paying more tax. We are starting to see similar consensus on the need for more funding for adult social care. This reflects a shift in public opinion over time about the reality and priority of social care funding.

- In the latest King's Fund quarterly monitoring report of changes and challenges facing health and social care, 'social care' was selected by NHS trust finance directors as the highest priority for investment of the new NHS funding.[57]
- 82 per cent of respondents to a 2018 NHS Confederation survey said that they support increasing public spending on social care by 3.9 per cent a year – compared to 77 per cent who support increasing healthcare spending by a similar amount (4 per cent).[58]
- In a 2017 Ipsos MORI poll, 71 per cent of respondents said that they would support an increase in income tax to pay for adult socialcare.[59]
- In a 2018 Ipsos MORI poll, four out of 10 named community and social care services as one of their top three priorities for any new funding – more support even than for routine surgery and primary care, and outstripped only by support for mental health services and urgent and emergency care.[60]
- A recent ComRes poll commissioned by the LGA found that 84 per cent of MPs and 81 per cent of Peers agree that additional funding should go to councils' social care budgets to tackle the funding crisis.
- Recent LGA public polling[61] suggests that 87 per cent of the public agree that councils should be given additional central government funding to deal with the funding gap in adult social care.
- A 2018 LGA poll of council leaders and social care cabinet members suggests that 96 per cent believe there is a major national funding problem in this area. 89 per cent said taxation must be part of the solution to securing the long-term sustainability of care and support.[62]

There has been considerable helpful recent debate about the different ways additional funding could be raised. They have included taxes on income, on property wealth, and cuts to other public spending. The table below summarises the key proposals which have been set out in public, drawing largely on previous reports, and the amount of money they are estimated to raise. We have conducted work to provide a broad estimate of the amount raised by the different options in 2024/25 (where others' work uses a different timescale) to ensure consistency between the figures used in the tables on page 54 and 58-59.

57 https://www.kingsfund.org.uk/publications/how-nhs-performing-june-2018

58 http://www.nhsconfed.org/news/2018/06/british-public-backs-increase-in-social-care-spending

59 https://www.ipsos.com/ipsos-mori/en-uk/majority-support-income-tax-rises-increase-funding-available-adult-social-care

60 http://nhsproviders.org/public-attitudes-to-health-and-care-new-nhs-providers-polling

61 ComRes surveyed 155 MPs (56 Conservative, 75 Labour, 12 SNP and 12 Other) and 103 Peers (30 Conservative, 40 Labour, 15 Liberal Democrat and 18 Crossbench/other) using a combination of paper and online surveys between 23 October 2017 and 11 December 2017. The key aims of this research were to track advocacy and efficacy against a comparator set of organisations; and measure attitudes towards local government funding and powers.

62 https://www.local.gov.uk/about/news/nine-ten-councils-say-national-taxation-key-solving-adult-social-care-funding-crisis

There are, of course, other broad options. For instance, during the 2017 General Election, the Conservative Party proposed aligning the means-test for domiciliary care with that for residential care[63] so that the value of a person's home would be taken account of along with other assets and income. Linked, they proposed extending deferred payments[64] to domiciliary care.

Some organisations have suggested that Attendance Allowance[65] and other benefits that support the same group of people could be reformed. For instance, the Barker Commission proposed repurposing Attendance Allowance as part of a new 'care and support allowance' to help meet lower levels of need. It could also be means tested. Roughly £5.5 billion a year is spent on Attendance Allowance, although some people spend their allocation on their care needs and others are charged against it so the full amount would not be in scope. More broadly, some people may argue that reprioritising Government expenditure is called for and it is of course in the national interest that we root out tax avoidance to ensure the Exchequer has the full extent of revenue it is owed by individuals and organisations. HMRC estimate that more than £30 billion of tax goes uncollected each year[66]. The default position, if additional funding is not raised by the above options or others, would be continued cuts to other local council services to protect adult social care, as we have described above.

CONSULTATION QUESTIONS:

16. Which, if any, of the options given for raising additional funding would you favour to pay for the proposed changes to the adult social care and support system?

17. Aside from the options given for raising additional funding for the adult social care and support system in local areas, do you have any other suggestions to add?

18. What, if any, are your views on bringing wider welfare benefits (such as Attendance Allowance) together with other funding to help meet lower levels of need for adult social care and support?

The LGA is not suggesting a preferred option. However, we are clear that a mix of solutions is likely to be required, both to reflect the scale of the funding challenge we face, which will continue to grow over time, and to reflect different individuals' and different generations' particular circumstances.

63 https://s3.eu-west-2.amazonaws.com/conservative-party-manifestos/Forward+Together+-+Our+Plan+for+a+Stronger+Britain+and+a+More+Prosperous....pdf

64 A deferred payment is an arrangement in which a council will (subject to eligibility criteria) pay for an individual's care home costs and recover those costs at a later point once the person's home is sold.

65 Attendance Allowance helps with personal support costs if you have a physical or mental disability and are aged 65 and over. It is paid at two rates, depending on the level of care you need (£57.30 or £85.60 a week). Unlike social care, it is not currently means-tested.

66 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/715742/HMRC-measuring-tax-gaps-2018.pdf

OPTION	FURTHER DETAIL	AMOUNT RAISED (based on other organisations' reports	AMOUNT RAISED 2024/25 (estimate)
Means-testing universal benefits (2017 Conservative Manifesto)	Means testing and/or better targeting of winter fuel payments and free TV licenses (ie limiting these benefits to people on pension credit)	Means testing winter fuel payments would raise £1.8 billion (2020/21)[9]	£1.9 billion[10]
Social Care Premium (Health and Social Care and Housing, Communities and Local Government joint select committee report)[11]	An earmarked contribution to which individuals and employers should contribute (such as an addition to National Insurance or another mechanism). Under 40s to be exempt and those beyond the age of 65 should contribute. Consideration to be given to a minimum earnings threshold to protect those on lowest incomes. This could be similar to a social insurance model. This could be voluntary or compulsory with different options for paying in – ie weekly, monthly, on retirement, deferred and paid from a person's estate. It could be private or state backed.		If it was assumed everyone over 40 was able to pay the same amount (not the case under National Insurance), raising £1 billion would mean a cost of £33.40 for each person aged 40+ in 2024/25 This is a purely illustrative figure and would not be the cost to individuals if the premium was attached to National Insurance given that a person's employment status and/or how much they earn determines the amount they contribute to National Insurance. in 2024/25[12]
1 per cent on Income Tax (Health Foundationand King's Fund and reproduced in joint select committee report)[13]	Basic	£3.8 billion (2020/21) £5.1 billion (2030/31)	£4.4 billion[14]

OPTION	FURTHER DETAIL	AMOUNT RAISED (based on other organisations' reports	AMOUNT RAISED 2024/25 (estimate)
	Higher	£1.3 billion (2020/21) £1.8 billion (2030/31)	£1.5 billion
	Top rate	£400 million (2020/21) £900 million (2030/31)	£450 million
1 per cent on National Insurance (Health Foundation and King's Fund and reproduced in joint select committee report)[15]	All rates	£9.1 billion (2020/21) £12 billion (2030/31)	£10.4 billion[16]
	Extend beyond retirement age given the increase in the number of people working beyond retirement age	£1 billion (2020/21) £1 billion (2030/31)	£1.1 billion
	Extend to some elements of pension income (Resolution Foundation – note this was presented as an option for funding an NHS spending increase)[17]	£2.5 billion (2022/23)	£2.6 billion[18]
1 per cent increase in council tax			£285 million[19]
Charging for accommodation costs in Continuing Health Care (Barker Commission)[20]	Means testing accommodation costs for people who receive continuing health care in a residential setting.	£200m estimate at the time the Barker review was published	£200 million

Please see page 86 for table footnote references

Beyond this, there are other tests we may wish to apply to judge the relative merits of any solution/s the Government puts forward in its green paper. These might include, for instance:

- **Wellbeing:** do the solution/s help advance the core aims of improving and supporting people's wellbeing, putting the individual at the centre of their care and support, and investing in the social and economic outcomes of our communities?
- **Fairness:** to what extent, and in what ways, do the solution/s help achieve a greater level of fairness for people? Do we understand the overall impact of the whole package of changes on different groups?
- **Sufficiency:** how much does the proposed solution/s raise in the short, medium and long-term? How does this compare to the costs of the type of options for change set out above?
- **Sustainability:** can we be confident that the funding is sufficient over time? If it is sufficient on day 1, will it be sufficient on day 2, day 100, day 1,000, and so on?
- **Clarity and transparency:** are the solution/s easy enough to understand and will they allow for clear lines of accountability on spending decisions?
- **Subsidiarity:** can national-level reforms be led as close as possible to the individual they are designed for?

CONSULTATION QUESTIONS:

19. What are your views on the suggested tests for judging the merits of any solution/s the Government puts forward in its green paper?

20. In your opinion, to achieve a long-term funding solution for adult social care and support, to what extent is cross-party co-operation and/or cross-party consensus needed?

Cross-party political co-operation

> "Whatever colour your rosette, I urge all politicians to come together and unite around the common aim that got us into politics in the first place: to improve our communities and the lives of the people who live within them."
>
> **Baroness Margaret Eaton DBE DL**
> LGA think piece series, 2018

Potentially difficult reforms to deliver a sustainable and fully funded care system in the future stand a greater chance of success if they are built on a degree of political consensus which can deliver cross-party co-operation, particularly in a parliament with a narrow majority.

Creating a constructive space in which the real issues and the full range of possible solutions can be debated could pave the way for a shared and concerted effort to raise awareness of social care with the public. This might include, for instance, an agreed cross-party narrative on why adult social care matters, how the system works, the challenges it faces, the level of funding required in the sort, medium- and long-term, and the types of options that are most likely and realistic to raise that level of funding.

This is not an impossible task. The recent joint report on long-term funding for adult social care by the Health and Social Care and Housing, Communities and Local Government select committees was a coming together of 22 MPs across four political parties. They reached consensus – not just in terms of articulating the problem but also in identifying, and crucially backing, a set of solutions for a way forward. Through this process, the LGA is seeking to develop a similar position, with similar cross-party support.

5. Adult social care and wider wellbeing

"Doctors and nurses can treat illness, but they cannot deliver health. Only healthy local communities can do that – and that is the role of local government."

Rt Hon Stephen Dorrell, Chairman, NHS Confederation
LGA think piece series, 2018

Key points:

- Tackling the full extent of future demand requires a shift in focus and a far greater emphasis on prevention and early intervention
- Public health has a fundamental role to play in this – investing in public health helps to deliver the wider prevention agenda that is critical to our health and care system overall
- Council services – including those provided by district councils – support people's wellbeing, as do those of councils' many local partners

As we have set out, adequately funding social care is a key part of the solution for a more secure long-term future for health and wellbeing. But if we are to really tackle the full extent of future demand with quality services we need to refocus our efforts on intervening earlier and preventing needs developing in the first place (or slowing their escalation). This is better for people and better for the public purse. Promoting healthy choices, protecting health, preventing sickness, intervening early to minimise the need for costly hospital treatment, supporting people to manage their own conditions or 'self-care', or providing support to unpaid carers requires the input of many council services and many of councils' local partners.

"We need to recognise that good support now will prevent more expensive hospital stays down the line" Lucy's story

The role of public health

The public health challenge in numbers…

Two thirds of adults and a quarter of two to 10 year olds are overweight or obese. Treating the consequences of obesity costs £5.5 billion to the health and social care system and has significant impacts on the quality of lives of people.

The proportion of adults who are overweight or obese is predicted to reach 70 per cent by 2034.

Alcohol-related crime accounts for about 920,000 violent incidents each year – accounting for 47 per cent of violent offences committed. The total annual cost to society of alcohol-related harm is estimated to be £21 billion. The NHS incurs £3.5 billion a year in costs related to alcohol.

Trips and falls cost the NHS more than £2 billion each year, with a 35 per cent increase in acute care costs in the year following a fall.

Loneliness and social isolation are as damaging to our health as smoking 15 cigarettes a day.

Local government is unanimous in its support for taking leadership of public health and working with local partners to achieve shared priorities. Councils are committed to making a difference to the lives of people in local communities by helping them live longer, healthier and more fulfilling lives. But this can only be achieved if we do things differently and resource public health services appropriately as part of wider investment across the system to help embed community-based prevention at all key points, including social care, the NHS and the voluntary sector.

In the 21st century, a huge part of the burden of ill health is avoidable. About a third of all deaths are classed as premature – that is they could have been prevented by lifestyle changes undertaken at an earlier time of life. The World Health Organization (WHO) estimateS that almost one third of the disease burden in industrialised countries can be attributed to four main behaviours: smoking, alcohol intake, poor diet, and lack of physical activity.

Without investment in prevention and early intervention, we will only ever see a continuation of the current vicious circle in which inadequate investment in these areas puts increasing pressure on hospitals, which then attract scarce resources. To put it another way, we need to tackle the cause of the pressures on hospitals and their budgets, not just keep treating the symptoms. Adequately resourcing public health is a sound investment precisely because it helps deliver the wider prevention agenda that is critical to the stability of our care and health services.

But when considering the cost of that illness it is not just the bill for treatment and care that should be taken into account. The economic consequences of premature death and

preventable illness are considerable, too. These can include loss of productivity in the workplace and the cost of crime and antisocial behaviour.

This is not a new argument. In 2002, the Wanless Report[67] put forward a strong case for investing more in public health, estimating that effective public health policy could save the NHS £30 billion a year by 2022/23. The report warned that, without investment in preventing ill health and changing our model of care services, the NHS would be financially unsustainable by 2014. This has come to pass. Spending on NHS care has more than doubled from £61 billion in 1994/95 to over £140 billion in 2016/17 (at 2016/17 prices)[68]. And even this has not been enough. Latest performance information from NHS Improvement shows that, for the year ending 31 March 2018, providers reported an aggregate deficit of £985 million. This was worse than both the forecast deficit at 2018/18 quarter three (£931 million) and the deficit in the previous financial year (£791 million)[69].

> "If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness"
>
> **NHS Five Year Forward View, 2014**

Councils are thinking creatively about their public health responsibilities and asking the central question: how do we use all of our resources for council-commissioned or provided services (and not just the modest ring fenced budget) to improve the health of our residents? This discussion is leading councils to think differently about how they affect the wider determinants of health and challenge established ways of working. Where services are not delivering value or significant outcomes they are being decommissioned and replaced by services that can deliver on local government's huge ambitions for local people.

The LGA has consistently highlighted that the potential contribution of public health is being undermined by funding constraints. Services and interventions that are vital for improving population health are not being implemented, or are being cut back, risking the future sustainability of the NHS. Council leaders have expressed particular concern that recent budget reductions will result in public health services that are inadequate for meeting the needs of the local populations they serve. And they have long warned that planned cuts by Government of £600 million between 2015 and 2020 are counterproductive and will only exacerbate the problems facing the NHS and social care.

CONSULTATION QUESTION:

21. What role, if any, do you think public health services should have in helping to improve health and wellbeing in local areas?

67 http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publichealth/Healthinequalities/Healthinequalitiesguidancepublications/DH_066213

68 HM Treasury Public Expenditure Statistical Analyses 2017

69 https://improvement.nhs.uk/documents/2852/Quarter_4_2017-18_performance_report.pdf

The role of other council services and those of local partners

As we have outlined already, council services make an important contribution to supporting people's wellbeing in the broadest sense. Within councils' highways and transport services for instance, close on £2.2 billion is spent on road maintenance, street lighting, traffic management and road safety, parking and concessionary fares, which all help create environments that are accessible and safe. Further spending totally nearly £2.1 billion is spent on councils' culture and related services, such as culture and heritage, recreation and sport, open spaces and library services. Such services help provide opportunities that get people out and about in their local communities. £332 million is spent on regulatory services that ensure high standards in trading, water safety, food safety and noise and nuisance protection. £266 million is spent on community safety measures and nearly £4.3 billion is spent on street cleaning, recycling and waste collection and disposal, creating communities that are safe, clean and accessible.

As the Association for Public Service Excellence has said:

> "The provision of high quality local neighbourhood services has a positive impact on the perception of an area, encourages physical activity in a community setting and fosters a sense of wellbeing with citizens. High quality neighbourhood services are complementary to social care, health services, police and fire services, education and housing. All other services thrive better in neighbourhoods that are deemed to be well managed, clean and safe.[70]"

It is precisely these sort of universal services that have been cut deeper to protect adult social care. To reiterate an earlier point, sorting out the long-term funding of social care therefore goes hand-in-hand with sorting out the long-term funding of services that play an essential role in creating communities we want to live in and which support our wider wellbeing. This includes the many vital frontline services commissioned and delivered by district councils that significantly impact the wider determinants of health and mitigate pressure on primary and social care. Of particular note are housing adaptations which help keep people out of hospital and allow them to return home safely in cases where time in hospital is required.

70 http://www.apse.org.uk/apse/assets/File/Neighbourhood%20Services%20(web).pdf

CONSULTATION QUESTIONS:

22. What evidence or examples, if any, can you provide that demonstrate the impact of other local services (both council services outside of adult social care and support, and those provided by other organisations) on improving health and wellbeing?

23.To what extent, if any, are you seeing a reduction in these other local services?

District councils are an equally important part of the equation when it comes to designing a system-wide focus on community-based prevention.

Housing more generally is a key component of health and care and the foundation upon which people, including those in vulnerable circumstances, can achieve a positive quality of life. The impact of poor housing on health is similar to that of smoking or alcohol and costs the NHS at least £1.4 billion a year, as well as creating housing worries that can end in homelessness for too many families[71].

The lack of available and appropriate general needs, social and private housing is putting pressure on supported housing provision, which provides a vital bridge between housing, support, care and health. Supported housing reduces cost pressures on public services by keeping people out of more costly health and care settings and providing the necessary support to address issues that might otherwise prevent independent living. Around £2.05 billion is spent on support and care services for people living in supported housing[72].

This comes from a variety of sources, including council adult social care and housing and homelessness funding.

It is not just councils that help support people's wellbeing. There are an estimated 36,000 voluntary, community and social enterprise (VCSE) organisations that support and provide health and social care services. The vast majority (nearly 90 per cent) are small, community-based organisations supported by an estimated three million volunteers[73]. This is an essential sector but one which faces its own pressures as demand for its services rises but state funding is constrained. This pressure is felt all the more by organisations that have relied, in part, on grants and contracts for their local councils, further reducing the impact of the local voluntary sector[74]. A sustainable voluntary sector is therefore a key component of wellbeing. As the Richmond Group of charities notes:

> "Funding for interventions and services that provide vital support for people with long-term conditions or that tackle our serious public health challenges needs to be more sustainable – moving away from the current situation in which as soon as public finances get tight, effective voluntary and community sector approaches get cut[75]"

71 https://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/87741-Cost-of-Poor-Housing-Briefing-Paper-v3.pdf

72 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655990/Funding_supported_housing_-_policy_statement_and_consultation.pdf

73 https://www.kingsfund.org.uk/sites/default/files/2018-02/Commissioner_perspectives_on_working_with_the_voluntary_community_and_social_enterprise_sector_1.pdf

74 https://www.thinknpc.org/publications/boldness-in-times-of-change/

75 https://richmondgroupofcharities.org.uk/sites/default/files/final_aw_5902_the_richmond_group_a4_10pp_report.pdf

6. Adult social care and the NHS

Key points:

- Our care model must change so that people experience it as a seamless package of care and support to address their specific needs and aspirations, helping them to live independent and fulfilling lives.
- Integration is not an end in itself but a means of improving health and wellbeing outcomes for individuals and communities, improving the planning and delivery of services and making the best possible use of resources
- The Better Care Fund has been a driver for joined-up planning but it should be locally-led by health and wellbeing boards
- Local government provides vital local leadership and democratic accountability. This must be harnessed, particularly through strengthened health and wellbeing boards, to address the democratic deficit in the NHS
- Council and health leaders are also best placed to drive improvement at the local level. The LGA, working with national partners, is committed to supporting local areas to improve and spread good practice.
- Extracting maximum value from the new NHS funding requires priorities to be set at the local level, with minimum top-down influence from government and the NHS nationally

Adult social care and health working together

'Integration' is not an end in itself but a means of achieving the triple aims of: improving health and wellbeing outcomes for individuals and communities; improving the planning and delivery of services; and making the best possible use of health and council resources. Neither is integration a panacea for the financial challenges of the health service and local government. Joining up care and support and intervening and offering early support to keep people well is a more efficient use of resources but efficiency alone is not enough to ensure the long-term sustainability of the health and care system.

The primary role of central government and national bodies in integration is to support and enable local leaders by removing the financial, cultural and structural barriers which prevent them acting for the good of their population, rather than the good of their own organisations. However, there has been increasing pressure from central government and the NHS at national level to direct integration and narrow its focus to reducing pressure on acute hospitals. In particular, the Better Care Fund (BCF)[76], originally intended as a spur to local leaders to create their own shared plans for joined up community based services, has been used as a tool of performance management.

The introduction of a new requirement in October 2017 for local BCF plans to comply with national targets for delayed transfers of care, or risk national direction or a review of their allocations, was a step too far in central influence. Developments such as these have,

76 The Better Care Fund was announced by the Government in the June 2013 Spending Round. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people. For further information, visit: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-fund

in many areas, undermined local partnerships rather than supported them.

The LGA continues to support the original intentions of the BCF[77]. Local leaders should have freedom to develop their own plans to promote integrated services, with national government playing a supportive and enabling role. But a number of factors, including financial challenges facing health and social care and the increase in national direction of local BCF plans, are identified as major barriers to greater joined up working. A recent LGA survey of council leaders and cabinet members for adult social care asked them to select the single biggest barrier to integration out of a list of ten possible choices. The top four barriers were identified as:

- Financial challenges (33 per cent)
- National direction and pressure to meet national targets (15 per cent)
- Workforce challenges (11 per cent)
- Lack of agreement between health and care leadership (10 per cent)

While local leaders can do their best to use the resources they have to support local joined-up working, there is a clear demand for national government to provide sufficient funding to support integration and give local leaders the space to develop and deliver their own plans.

If this cannot be achieved, the BCF should be reformed with resources going directly to councils and deployed according to locally agreed plans overseen and assured by health and wellbeing boards.

CONSULTATION QUESTION:

24. What principles, if any, do you believe should underpin the way the adult social care and support service and the NHS work together?

Joining up support around the person

The primary purpose of integration is to provide better and more effective care and support to people, enabling them to live more fulfilling and independent lives. Professionals across health and care working together to join up or coordinate services undoubtedly improves people's experience of services. But on its own it is not sufficient to deliver personalised care. To make real progress on this ambition, we need to put the person at the centre of our planning and for professionals to work with them to identify what they most value in their lives and how we can enable them to achieve it.

Personalisation is not a new concept in social care. For well over a decade, adult social care has worked with people who use services to design and recommission services to ensure that they have more choice and control. Through the Think Local Act Personal (TLAP) partnership initiative, local government and partners have committed to transforming health and social care through personalisation and community-based support.

77 The Better Care Fund was announced by the Government in the June 2013 Spending Round. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people. For further information, visit: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-fund

The 'Making it Real' (MiR)[78], framework developed by TLAP in partnership with people who use services and carers, describes the outcomes that genuinely personalised care and support should achieve in delivering more choice and control.

The MiR approach uses first person 'I' statements or 'progress markers' to express what service users and carers would expect to find, if personalisation is working and supporting them to be active, healthy citizens. A review by TLAP of the MiR approach demonstrated that those councils who have signed up and completed their MiR action plans:

- have a greater increase in the numbers of people who use direct payments
- have higher satisfaction levels of people who feel they have control over their life
- have provided more support to carers.

Local government has shown that personalised care at scale is possible. For example, over 500,000 people have a personal budget of whom 154,000 people have a direct payment or part-direct payment[79] in order to purchase the support they need.

Though it originated in adult social care, personalisation is now a central principle of health care as demonstrated by The Five Year Forward View[80] which recognised that many people have the knowledge, skills and confidence to manage their mental and physical health and wellbeing and want to make choices and have control of the care and support they receive. The LGA has worked with NHS England to develop the Integrated Personal Commissioning programme to spread joined-up and personalised care across health and social care, focusing on shared decision making; personalised care and support planning; enabling choice, including legal rights to choice; social prescribing and community-based support; supported self-management and greater access to personal health budgets and integrated personal budgets.

We support the commitment to ensuring that whole-person integrated care is a founding pillar of a future care and support system[81]. A sustainable approach to health and social care must have personalisation at its heart. Not just because this is what people want, but also because it has the power to transform the way professionals work with people and the way the system works, and this can help to transform lives.

78 Making it Real website (which includes support materials, case studies, films and examples of Making it Real action plans): www.thinklocalactpersonal.org.uk/Browse/mir

79 NHS Digital (2016), Adult social care activity and finance report, England 2016-17 – table T27 Available online: https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/adult-social-care-activity-and-finance-report-england-2016-17 (accessed 7 June 2018)

80 NHS England (2014), Five Year Forward View. Available online: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (accessed 3 June 2018)

81 https://www.gov.uk/government/speeches/we-need-to-do-better-on-social-care

All of this will necessitate identifying the new roles and skills which will be needed in the system and funding for sustainable skills development. For instance, it may be worth exploring ways in which the new apprenticeship levy can be used more flexibly to help here but other funding will be needed given the anticipated demand for carers.

Local government, local leadership

Local government leadership is highly effective in driving forward an inclusive, place-based approach to improving health and care services and outcomes. Though only two integrated care systems[82] are led by local council senior officers, they have demonstrated how local government can firmly embed plans to transform health and wellbeing into the wider local landscape. Local government is able to use its direct connections with communities through its democratic mandate to have honest and inclusive conversations about the rights and responsibilities of citizens with regard to their health and wellbeing. And it can also link community-based health and wellbeing services to existing community-based services, which are easily accessible to and trusted by people.

A good example of this is the Nottingham and Nottinghamshire Integrated Care System, which is led by David Pearson, Director of Adult Social Care, Health and Public Protection at Nottinghamshire County Council. It has worked closely and inclusively with its communities, workforce and partners to develop a plan that is very much grounded in the promotion of health and wellbeing, prevention, independence and self-care, through supporting community resilience and capacity building. It also recognises the vital need to strengthen primary, community, social care and carer services and the role of housing in supporting wellbeing. The fact that Nottinghamshire was selected as one of the first 10 integrated care systems is evidence that local government leadership is effective in developing a strongly inclusive place-based approach.

Accountability in the NHS

Public polling shows that people trust local councillors more than national politicians to make the right decision for their area. However, the NHS is accountable upwards to the Government, through NHS England, rather than outwards to its communities, through local councillors. The 2012 Health and Social Care Act went some way to addressing the democratic deficit in the NHS by creating health and wellbeing boards (HWBs). The boards are an equal partnership of political, clinical, professional and community leaders, with powers and duties to develop their own place-based strategy for improving the health and wellbeing outcomes of the population. HWBs are variable in their impact and influence. The front runners have undoubtedly driven local plans to develop a new approach to health and wellbeing, which invests in promoting wellbeing, early help and support delivered through joined-up community-based services and advice and information to help people manage their own health. However, not all HWBs have been effective in leading the transformation of health and care services. The LGA continues to support HWBs to ensure that they have an impact on the health and wellbeing of their communities and lead the transformation agenda.

82 Integrated care systems are a new type of even closer collaboration in which NHS organisations, local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

Yet the democratic deficit in the NHS continues, in part due to the disconnect between HWBs and Sustainability and Transformation Partnerships (STPs), set up in 2015 to deliver the NHS Five Year Forward View. Though the LGA supports the intentions of STPs, the way in which they have been implemented in many areas has largely excluded existing democratic processes and has failed to engage councillors or communities in developing plans to transform services. In a recent LGA survey of council leaders and cabinet members for health and social care were asked about the extent to which they were making progress with various partners on integration in their local area. The responses are summarised below:

TO WHAT EXTENT ARE YOU MAKING GOOD OR MODERATE PROGRESS ON INTEGRATION WITH YOUR PARTNERS?

- Council – 87 per cent
- Health and wellbeing board – 84 per cent
- Clinical commissioning group – 81 per cent
- NHS providers – 72 per cent
- Integrated care system – 54 per cent
- Sustainability and transformation partnership – 48 per cent
- NHS England – 26 per cent

It is clear that council leaders and lead members feel strongly that local councillors working with their health commissioning and provider partners are best placed to lead integration, with only 48 per cent reporting good or moderate progress in working with STPs. This is a serious cause for concern as STPs have been given the leadership of place-based integration within the NHS. Unless HWBs are given additional powers they will continue to be bypassed by STPs and people will remain unclear about how decisions are taken within the NHS at the local level. Strengthening the role of HWBs could take various forms:

- STPs could be required to engage with HWBs in the development of STP plans
- HWBs could be given a statutory duty and powers to lead the integration agenda at the local level
- HWBs could assume responsibility for commissioning primary and community care

CONSULTATION QUESTIONS:

25. In your opinion, how important or unimportant is it that decisions made by local health services are understood by local people, and the decision-makers are answerable to them?

26. Do you think the role of health and wellbeing boards should be strengthened or not?

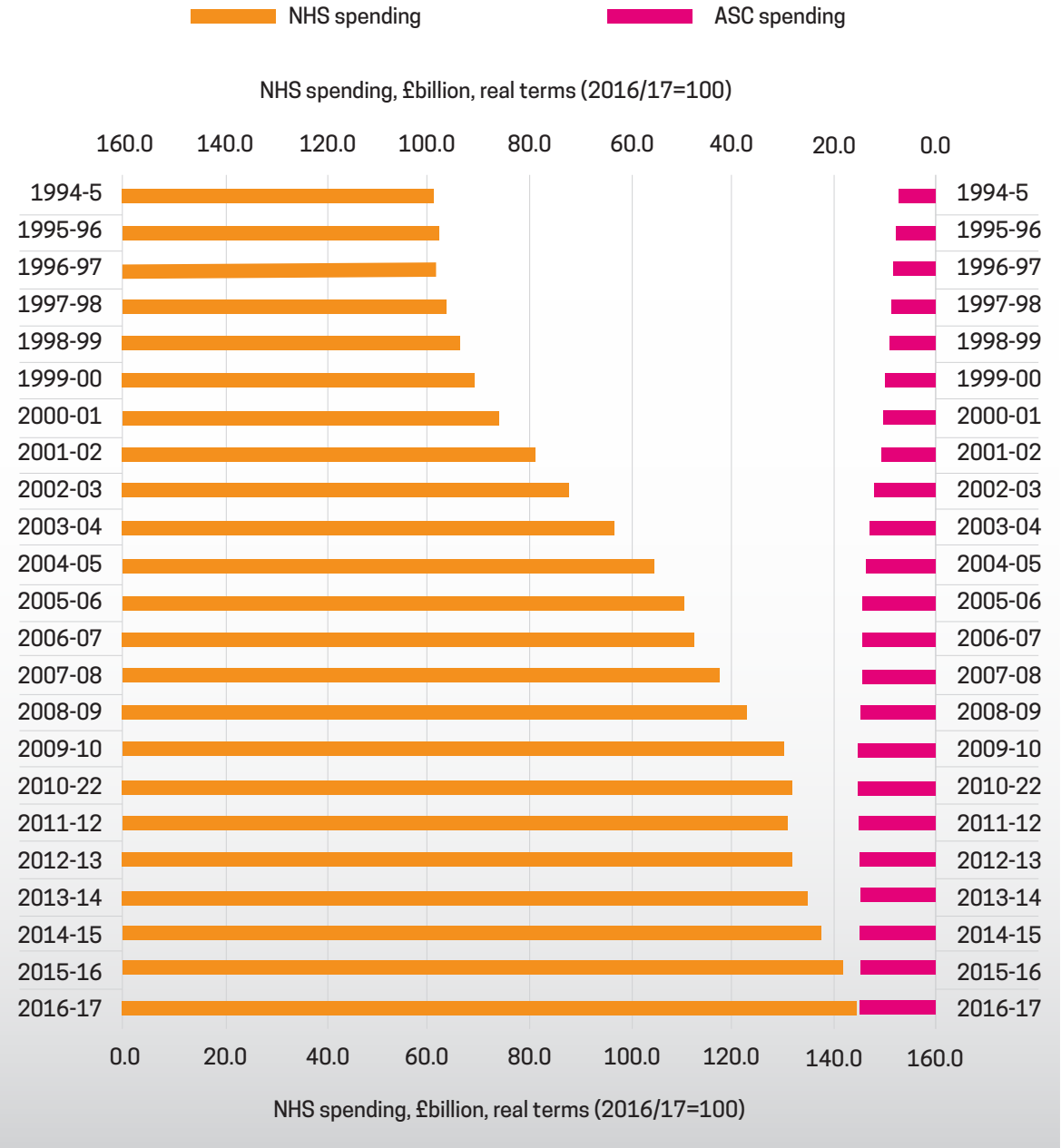
27. Which, if any, of the options for strengthening the role of health and wellbeing boards do you support?

28. Do you have any suggestions as to how the accountability of the health service locally could be strengthened?

New NHS funding – how it can benefit the system

Historically as a nation we have spent far more on the NHS than on adult social care, as the following chart shows.

NHS AND ADULT SOCIAL CARE SPENDING 1993-2017



Source: HM Treasury Public Expenditure Statistical Analyses 2017 and NHS digital data on adult social care spending, multiple years

Bringing about the shift from treating conditions to maximising wellbeing requires rethinking how additional resources are used to best effect. The NHS has been promised significant additional new funding, rising to £20.5 billion by 2023/24, an average of 3.4 per cent growth over the next five years. The linked NHS ten year plan is an opportunity to set out how our health service will develop over the next decade as part of efforts to ensure a world-class NHS. That aspiration can only be achieved if the NHS plan, and the new NHS funding, is used to best effect. But that assumes that the new NHS funding is sufficient and many commentators have already questioned this. For example, the Institute of Fiscal Studies and Health Foundation suggest that "spending on healthcare will have to rise by an average 3.3 per cent a year over the next 15 years just to maintain NHS provision at current levels, and by at least 4 per cent a year if services are to be improved"[83].

Similarly, NHS Providers have warned that "filling the gaps that have opened up in the health service after almost a decade of austerity will account for much if not most of the new money"[84]. If such commentators are right, we run the risk of yet again using scarce new resources to manage demand pressures on our hospitals. This would be a missed opportunity to bring about more fundamental change and ensure maximum value is extracted from the £20 billion. Maximum value of the new funding should be defined at the local level, with minimal top-down initiatives from government and NHS England and maximum input from communities, workforce, service users and patients.

83 https://www.ifs.org.uk/uploads/R143.pdf#page=6

84 http://nhsproviders.org/news-blogs/news/recovering-nhs-performance-risks-swallowing-up-new-funding

With sufficient local flexibility, the funding could be used to:

- Invest in prevention, primary care and community health services, with multiagency teams working closely alongside the voluntary sector to put in place early help and support
- Reinvigorate investment in intermediate care
- Reverse the cuts to district nursing, particularly so that district nurses can support care homes and extra care facilities
- Fund GP support in nursing homes and care homes to keep people out of hospital
- Fund care navigators in GP surgeries
- Invest in joined-up infrastructure, such as joint commissioning, joint assessment and shared information to track people through the health and care system and joint workforce planning
- Invest in skills development with councils taking more responsibility
- Take personalisation further with a single assessment and care planning process, which is centred on the individual and what matters to them
- Ensure that what digital activity gets delivered through the NHS Plan recognises – and funds – the critical interface with councils and the care sector, with support being given to the sharing of information through local shared records

CONSULTATION QUESTIONS:

29. Which, if any, of the options for spending new NHS funding on the adult social care and support system would you favour?

30. Do you have any other comments or stories from your own experience to add?

7. Summary of key points

Delivering and improving wellbeing

- We are best able to live the life we want to live if we are independent, well and live in communities that support and encourage the many aspects that make us unique.
- This is true for everyone but the support we may need is unique to us as individuals and must therefore be personalised.
- Local government exists for this very purpose, affecting multiple dimensions of our communities and lives, throughout our lives.
- Supporting and improving people's mental and physical wellbeing is at the heart of local government's work and that of many other local public, private and voluntary sector organisations, it can only be delivered with communities.

Setting the scene – the case for change

- Social care and support matters to individuals, our communities, our NHS and our economy.
- The local dimension of social care matters because it ensures the service is accountable to local people.
- Despite a challenging financial environment, social care has delivered – it has improved and innovated.
- While diversity of local care and support is the positive result of a health and care system that is responsive to the diversity of the community it serves, unwarranted variation in quality, access and outcome is not acceptable. Local government is committed to addressing this and is best equipped to lead improvement.
- Significant reductions to councils' funding from national government is now jeopardising the impact local government can have in communities across the country.
- In particular, the scale of funding pressures within adult social care threatens progress made to date and now risks people's wellbeing and outcomes and the stability of the wider system.
- There are continuing recruitment and retention challenges in the adult social care workforce.
- The Care Act remains the right legal basis for social care but funding pressures are threatening the spirit and letter of the law.

The options for change

- Social care is becoming a greater public priority.
- The public and politicians (local and national) support greater funding for social care.
- People find the social care system complex and confusing, it is hard to understand, particularly for those facing the immediate pressures of requiring care and having to engage with a system they have never encountered before.
- People worry about the costs of social care but are not making preparation for them and the rules are not clear.
- Although it is hard to define, people want a greater sense of fairness within social care.
- There are a number of options for making social care better.

- Making these changes will require more funding. There are different ways of raising this.
- Cross-party consensus or co-operation must be sought to secure a workable long-term solution.

Adult social care and wider wellbeing

- Tackling the full extent of future demand requires a shift in focus and a far greater emphasis on prevention and early intervention.
- Public health has a fundamental role to play in this – investing in public health helps to deliver the wider prevention agenda that is critical to our health and care system overall.
- Council services – including those provided by district councils – support people's wellbeing, as do those of councils' many local partners.

Adult social care and the NHS

- Our care model must change so that people experience it as a seamless package of care and support to address their specific needs and aspirations, helping them to live independent and fulfilling lives.
- Integration is not an end in itself but a means of improving health and wellbeing outcomes for individuals and communities, improving the planning and delivery of services and making the best possible use of resources.
- The Better Care Fund has been a driver for joined-up planning but it should be locally-led by health and wellbeing boards.
- Local government provides vital local leadership and democratic accountability. This must be harnessed, particularly through strengthened health and wellbeing boards, to address the democratic deficit in the NHS.
- Council and health leaders are also best placed to drive improvement at the local level. The LGA, working with national partners, is committed to supporting local areas to improve and spread good practice.
- Extracting maximum value from the new NHS funding requires priorities to be set at the local level, with minimum top-down influence from government and the NHS nationally.

8. Have your say

Your views matter. Our green paper is only a starting point and we want to build momentum for a debate across the country about how to fund the care we want to see in all our communities for adults of all ages and how our wider care and health system can be better geared towards supporting and improving people's wellbeing.

Throughout our green paper we have posed a series of consultation questions (set out below) and we would welcome your views on all those that are important to you. The consultation will run from 31 July to 26 September. Once the consultation closes we will analyse all responses and publish a response in the autumn.

To complete the consultation you can either visit **www.futureofadultsocialcare.co.uk** and complete the online survey under the section titled 'The Green Paper', alternatively you can submit your answers to the questions below to: **socialcareconversation@local.gov.uk**.

If you are responding as an individual there is also an option to answer the questions in the 'Summary Green Paper' section which are primarily focussed on gathering experience-based evidence and opinions. Again, this can be done online or via the **socialcareconversation@local.gov.uk** inbox.

1. **What role, if any, do you think local government should have in helping to improve health and wellbeing in local areas?**

2. **In what ways, if any, is adult social care and support important?**

3. **How important or not do you think it is that decisions about adult social care and support are made at a local level?**

4. **What evidence or examples can you provide, if any, that demonstrate improvement and innovation in adult social care and support in recent years in local areas?**

5. What evidence or examples can you provide, if any, that demonstrate the funding challenges in adult social care and support in recent years in local areas?

6. What, if anything, has been the impact of funding challenges on local government's efforts to improve adult social care?

7. What, if anything, are you most concerned about if adult social care and support continues to be underfunded?

8. Do you agree or disagree that the Care Act 2014 remains fit for purpose?

9. What, if any, do you believe are the main barriers to fully implementing the Care Act 2014?

10. Beyond the issue of funding what, if any, are the other key issues which must be resolved to improve the adult social care and support system?

11. Of the above options for changing the system for the better, which if any, do you think are the most urgent to implement now?

12. Of the above options for changing the system for the better, which if any, do you think are the most important to implement now?

13. Thinking longer-term, and about the type of changes to the system that the above options would help deliver, which options do you think are most important for the future?

14. Aside from the options given for improving the adult social care and support system in local areas, do you have any other suggestions to add?

15. What is the role of individuals, families and communities in supporting people's wellbeing, in your opinion?

16. Which, if any, of the options given for raising additional funding would you favour to pay for the proposed changes to the adult social care and support system?

17. Aside from the options given for raising additional funding for the adult social care and support system in local areas, do you have any other suggestions to add?

18. What, if any, are your views on bringing wider welfare benefits (such as Attendance Allowance) together with other funding to help meet lower levels of need for adult social care and support?

19. What are your views on the suggested tests for judging the merits of any solution/s the Government puts forward in its green paper?

20. In your opinion, to achieve a long-term funding solution for adult social care and support, to what extent is cross-party co-operation and/or cross-party consensus needed?

21. What role, if any, do you think public health services should have in helping to improve health and wellbeing in local areas?

22. What evidence or examples, if any, can you provide that demonstrate the impact of other local services (both council services outside of adult social care and support, and those provided by other organisations) on improving health and wellbeing?

23. To what extent, if any, are you seeing a reduction in these other local services?

24. What principles, if any, do you believe should underpin the way the adult social care and support service and the NHS work together?

25. In your opinion, how important or unimportant is it that decisions made by local health services are understood by local people, and the decision-makers are answerable to them?

26. Do you think the role of health and wellbeing boards should be strengthened or not?

27. Which, if any, of the options for strengthening the role of health and wellbeing boards do you support?

28. Do you have any suggestions as to how the accountability of the health service locally could be strengthened?

29. Which, if any, of the options for spending new NHS funding on the adult social care and support system would you favour?

30. Do you have any other comments or stories from your own experience to add?

Annex A: Case studies of innovation, delivery and performance

Prioritising care and support: Between 2010 and 2017, adult social care has had to make savings and reductions worth £6 billion as part of wider council efforts to balance the books. But the service continues to be protected relative to other services. The latest ADASS budget survey shows that adult social care accounts for a growing total of councils' overall budgets, up from 36.9 per cent in 2017/18 to 37.8 per cent in 2018/19[85]. As a result, by 2019/20, 38p of every £1 of council tax will go towards funding adult social care.

Innovating: Councils are committed to innovation to help reduce costs while maintaining or improving services to the public. This has included changing the way that demand is managed, more effectively using the capacity in communities to help find new care solutions, and working more closely with partners in the NHS to reduce pressures in the care and health system. Innovative approaches can be found in all parts of the country.

- Kent County Council is driven, like many councils, by the daily challenge of ensuring people have what they need to enable them to leave hospital safely. Daily multi-disciplinary meetings help to identify and reduce delayed transfers of care and weekly improvement cycle meetings address the reasons for the delays. Staff training and good performance management have helped to embed the ethos, resulting in a 59 per cent reduction of people being discharged into residential care and a 54 per cent reduction in people being discharged into short-term beds. This equates to 350 additional people going to live back at home each year. In 2017 Kent saw 911 fewer residential and nursing care placements compared to 2013.
- Kirklees Metropolitan District Council's 'Gateway to care', co-located with community health, is a multidisciplinary 'front door' which provides simple care packages for a rapid response, care navigation, assistive technology provision and safeguarding support. Care navigators, located in four community hubs, help to embed a strengths-based approach by building community capacity and supporting people to find solutions in those communities. The front door deals with the majority of contacts first time, with just 6 per cent going on to a full assessment. In 2017/18 almost half of those with eligible care needs achieved good outcomes through community support, saving the council over £1.9 million.
- Bristol City Council is changing the conversation it has with residents when they first make contact with adult social care, focusing on finding help and support from communities rather than from formal care services. This has resulted in 75 per cent of first contacts being referred to community support, with two thirds of those making contact saying that they felt positive about how they had been treated. In the first year, this approach has saved £6 million[86].
- In Swindon Borough Council, a review of patient cases showed that when someone was discharged to a residential care setting, 45 per cent of the time they would have achieved

85 https://www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf
86 https://www.local.gov.uk/sites/default/files/documents/25.43%20Chip%20Efficiency%20Project_03_1.pdf

a better outcome had they been supported to return home (either with domiciliary reablement, or via intermediate residential reablement). However, neither of these services had the capacity or capability to take the additional volume of patients. Swindon's health and social care teams designed and led a change programme which has achieved a 163 per cent increase in patients receiving reablement services, daily internal coordination meetings and a reduction in social care delayed transfers of care from 450 days in May 2017 to 30 days in March 2018. It has also resulted in an annual saving of over £1.9 million to the health and social care economy.

- Somerset County Council has worked with the social enterprise Community Catalysts to stimulate micro-providers to develop care and support services in rural areas. This enables people to get support from community enterprises in ways, times and places that suit them and their families, rather than from formal support services. This initiative has led to the development of a flourishing social enterprise sector with 178 providers offering low cost, flexible care and support to older and disabled people and their families. In the first year, care has been offered to over 700 people, collectively delivering 3,600 hours of care a week. The council estimates that this approach has saved over £800,000 a year while offering people a far more flexible and accessible service[87].

- Bristol City Council, North Somerset Council and Bath and North East Somerset Council jointly commission sector-leading care and repair services across all three council areas from a single organisation, West of England Care & Repair (WEC&R). The councils have pooled their resources to secure economies of scale in the delivery of a range of services to support older and disabled people to live well in their existing homes, for example through providing home improvements, handyperson services, adaptions and support with hospital discharge. The scale of the contract has enabled WEC&R to 'lever in' additional funding from grants, and to secure additional private funding to complement the funding from councils. More older and disabled people are receiving a service in addition to what can be delivered from the core funding and for WEC&R it provides a viable and sustainable business.[88]

- Patients in Mendip seeing a doctor can be referred to Health Connections Mendip, a team employed by the 11 Mendip general practices. Patients can discuss what is important to them and the team can help them access the support they might want. The End Loneliness Campaign in Mendip signposts people to clubs and activities, such as Talking Cafes, line dancing classes, community transport, men's sheds and befriending services. Health Connections Mendip have a team of more than 600 Community Connectors – such as café owners, drivers, supermarket staff – who on average talk to about 20 people a year which means more than 12,000 signposting conversations a year. Health Connections

87 https://www.local.gov.uk/sites/default/files/documents/25.43%20Chip%20Efficiency%20Project_03_1.pdf

88 https://www.local.gov.uk/sites/default/files/documents/5.17%20-%20Housing%20our%20ageing%20population_07_0.pdf

Mendip works as part of a team which includes primary care, secondary care, adult social care, voluntary sector, town and district councils and the wider community. This partnership working has led to a 20 per cent reduction in local hospital admissions which is saving £2 million on the public purse. Every £1 spent on the scheme saves the NHS £6.[89]

- Central Bedfordshire Council has addressed the housing needs of its older population by using a detailed qualitative and quantitative evidence base to produce an 'investment prospectus' that sets out its vision and development opportunities. It is a more attractive and engaging approach to stimulating the market than a traditional 'market shaping' document. The prospectus specifically identifies the range of opportunities that will, collectively, address the identified demographic, housing and care/support needs, as well as the aspirations and requirements of older people. Delivery outcomes from this innovative way of engaging providers and promoting investment in housing solutions for older people include:
  - A council-developed extra care housing scheme of 83 units in Dunstable.
  - A private sector 'rightsizer' housing scheme of 32 units in Dunstable.
  - Two new care homes with 141 beds in Dunstable enabling the council to close some of its in-house outdated care home provision.
  - A housing association extra care housing scheme of 81 units in Leighton Buzzard.[90]
- Councils are at the forefront of promoting choice and control through personal budgets. For example, in Harrow the council is working with the CCG to extend the My Community e-Purse system, which supports purchasing social care services and equipment via personal budgets to people with a personal health budget. This project will benefit people, their carers and their families by giving them more control and choice over their carer and support choices. It will also enable closer working between health and social care and find ways of releasing funding tied up in secondary care that could be more effectively used in social care. The council will manage 259 personal health budgets on behalf of the CCG and it is estimated that the savings – to be realised in 2018/19 – will be £147,000 based on the estimated 7 per cent savings that the council's e-Purse system has already achieved.[91]
- Shared Lives is a vital and highly praised approach which matches young people or adults who need support with an approved Shared Lives carer, who provides personal care and either a home or a place to visit regularly. Of the 14,000 people using Shared Lives, half live with their Shared Lives carer and half visit for day support or overnight breaks. My Shared Life[92] is an online platform that enables people to give their experience of the service. Responses from over 200 people in Shared Lives shows that:

89 https://www.local.gov.uk/about/news/loneliness-initiatives-cutting-emergency-hospital-admissions-20-cent

90 https://www.local.gov.uk/sites/default/files/documents/5.17%20-%20Housing%20our%20ageing%20population_07_0.pdf

91 London Borough of Harrow Case Study, Care and Health Improvement Programme, April 2018, https://www.local.gov.uk/sites/default/files/documents/London%20Borough%20of%20Harrow%20LIP%20Case%20Study.pdf

92 https://sharedlivesplus.org.uk/short-breaks/item/484-my-shared-life

- 92 per cent of people felt that their Shared Lives carer's support improved their social life.
- 81 per cent of people felt that their Shared Lives carer's support made it easier for them to have friends.
- 73 per cent of people felt involved with their community but 93 per cent felt their Shared Lives carer's support helped them feel more involved.
- 85 per cent of people felt their Shared Lives carer's support helped them have more choice in their daily life.
- 84 per cent of people felt their Shared Lives carer's support improved their physical health.
- 88 per cent of people felt their Shared Lives carer's support made their emotional health better.

- Councils are supporting people with dementia. Sutton Council funds Admiral Nurses to give support to people living with dementia and their families. This has been supported by the local CCG, which recognises the value of providing extra support to these families. And Cumbria County Council is building three new council care homes to cater for residents with advanced frailty and dementia. This has been identified as an area where not enough private provision is available.
- Digital and technology can play a key role in wider service redesign. It can help make the shift from treatment to prevention and there is a growth in consumer-based technology that can be purchased on the high street to support people remain independent at home. It can also help providers deliver more effective person-centred care and we are seeing examples of providers (across care settings) using technology to help improve communication with friends, family and those receiving care.
- A number of councils including Hampshire, Barnet, Lancashire and Wolverhampton are using care technology to support people to remain independent at home for longer. In Hampshire, 8,600 people are being supported with 94 per cent of people saying that these approaches increase their feelings of safety and security. Ninety-eight per cent of people would recommend the service to others. It is a similar picture in Lancashire where 8,400 people are being helped to maintain independence and safety.
- Areas such as Leeds, Stockport, Bristol, Dorset and Bracknell Forest are bringing information together from the council and health providers which is reducing the need for service users to have to tell their story multiple times. In Luton and Central Bedfordshire, care homes are being supported to improve sharing of information through access to NHS Mail and shared care records. The project with the ultimate goal of fully shared records is now being expanded to all care homes in the region.
- There are a number of new social care technology-based start-ups emerging, which are using technology to improve the delivery of person-centred care. These providers are using technology to better match care workers to clients and digitising the care records so that carers can log on to information about their clients using their smartphone. Other care providers are using technology to store notes about

clients, read up on those they are visiting and using it as a way to raise the alert if anything is wrong. Families and friends can receive notifications and log in to see how care for their family member is proceeding. These forms of technology are enabling care providers to improve the delivery of person-centred care whilst improving business efficiency of care providers. In Liverpool the council has worked to bring the home care provider sector together with technology suppliers which has resulted in the digitisation of care records and introduction of a network that allows for improved monitoring of people requiring care and support at home.

Intervening early and preventing needs: Investing in prevention has clear benefits for people and reduces costs to the wider care and health system.

- Falls prevention programmes run by councils and their partners reduce the number of falls requiring hospital admission by 29 per cent. This represents a return on investment of more than £3 for every £1 spent.[93]
- Research on Disabled Facilities Grant (a council grant to help disabled people make changes to their home) shows that every £1 spent on housing adaptations is worth more than £2 in care savings and quality of life gains.[94]
- Evaluation of the Handyperson Programme has shown that handyperson services support large numbers of older and disabled people to live independently at home for longer and with greater comfort and security. Services include small repairs and minor adaptations that reduce the risk of falls, home security measures to help maintain independent living, and energy efficiency checks to help reduce excess winter deaths[95].
- Partners in Leicester are improving hospital discharge and avoiding unnecessary admissions through, for instance, an 'integrated lifestyle hub' tackling the wider determinants of health, GP-led care planning for patients identified via a risk stratification system, wrap-around rapid access to services such as assistive technology, falls assessment and equipment, and proactive discharge follow-up for at-risk groups. As a result, attendances in A&E in quarter one of 2017/18 were down by 2.9 per cent from the same point in 2016/17.[96]
- The Kent Pathway Service supports adults with a learning disability to achieve a more independent life. It supports people for between one and 12 weeks to learn or re-learn skills that help them become more independent and need less support. This has also led to an outcomes-focused practice project for people with a learning disability which aims to adopt a strength-based approach by setting goals and monitoring that providers are delivering and undertaking practice reflection sessions.[97]

93 https://www.local.gov.uk/about/news/hospital-admissions-due-falls-older-people-set-reach-nearly-1000-day
94 https://www.local.gov.uk/sites/default/files/documents/building-our-homes-commun-740.pdf
95 https://www.local.gov.uk/sites/default/files/documents/prevention-shared-commitm-4e7.pdf
96 For further information, visit: https://www.local.gov.uk/leicester-journey-improving-discharge-and-avoiding-admissions
97 https://www.local.gov.uk/sites/default/files/documents/lga-learning-disability-s-d9a.pdf

- Darlington Council adopted the progression model, making enablement a priority. High cost packages of care and in-house services in supported tenancies, day opportunities and short break stays were prioritised as areas of greatest opportunity. Following a strengths-based assessment, James, an individual with a learning disability, moved from residential care to his own tenancy and transferred to tenancy support, making an annual saving of £88,600 to adult social care.[98]

Performing: The Adult Social Care Outcomes Framework (ASCOF) measures how well care and support services achieve the outcomes that matter most to people. Latest information from October 2017 (for 2016/17)[99] shows that, even in the deeply challenging financial environment social care has operated in over the last few years, performance has improved or been maintained in several key areas. The Personal Social Services Adult Social Care Survey (for 2016/17)[100] also provides encouraging findings:

- 64.7 per cent of service users are extremely or very satisfied with the care and support services they received.
- 67.6 per cent of service users in the community reported that they have enough choice over the care and support services they receive.
- The proportion of people who use services who have control over their daily life is currently at its highest level (77.7 per cent) in the reporting period (2014/15 to 2016/17).
- The proportion of adults with a learning disability who live in their own home or with their family is currently at its highest level (76.2 per cent) in the reporting period.
- The proportion of people aged 65+ still at home 91 days after discharge from hospital into reablement/rehabilitation services is currently at its second highest level (82.5 per cent) in the reporting period.

The proportion of people who use services who say that those services have made them feel safe and secure is currently at its highest level (86.4 per cent) in the reporting period.

The City of Wolverhampton Council is improving outcomes whilst creating a financially sustainable service through the creation of a 'Promoting Independence Team' to undertake overdue reviews. To date, 700 cases have been reviewed, 22 per cent of which resulted in a decrease in the size of the care package, delivering a saving of £900,000 per annum. Use of the ASCOF tool to measure quality of life at start and end of intervention indicated that people felt more in control and were achieving better quality of life outcomes following the review.

98 https://www.local.gov.uk/sites/default/files/documents/lga-learning-disability-s-d9a.pdf
99 https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current
100 https://files.digital.nhs.uk/pdf/d/5/pss-ascs-eng-1617-report.pdf

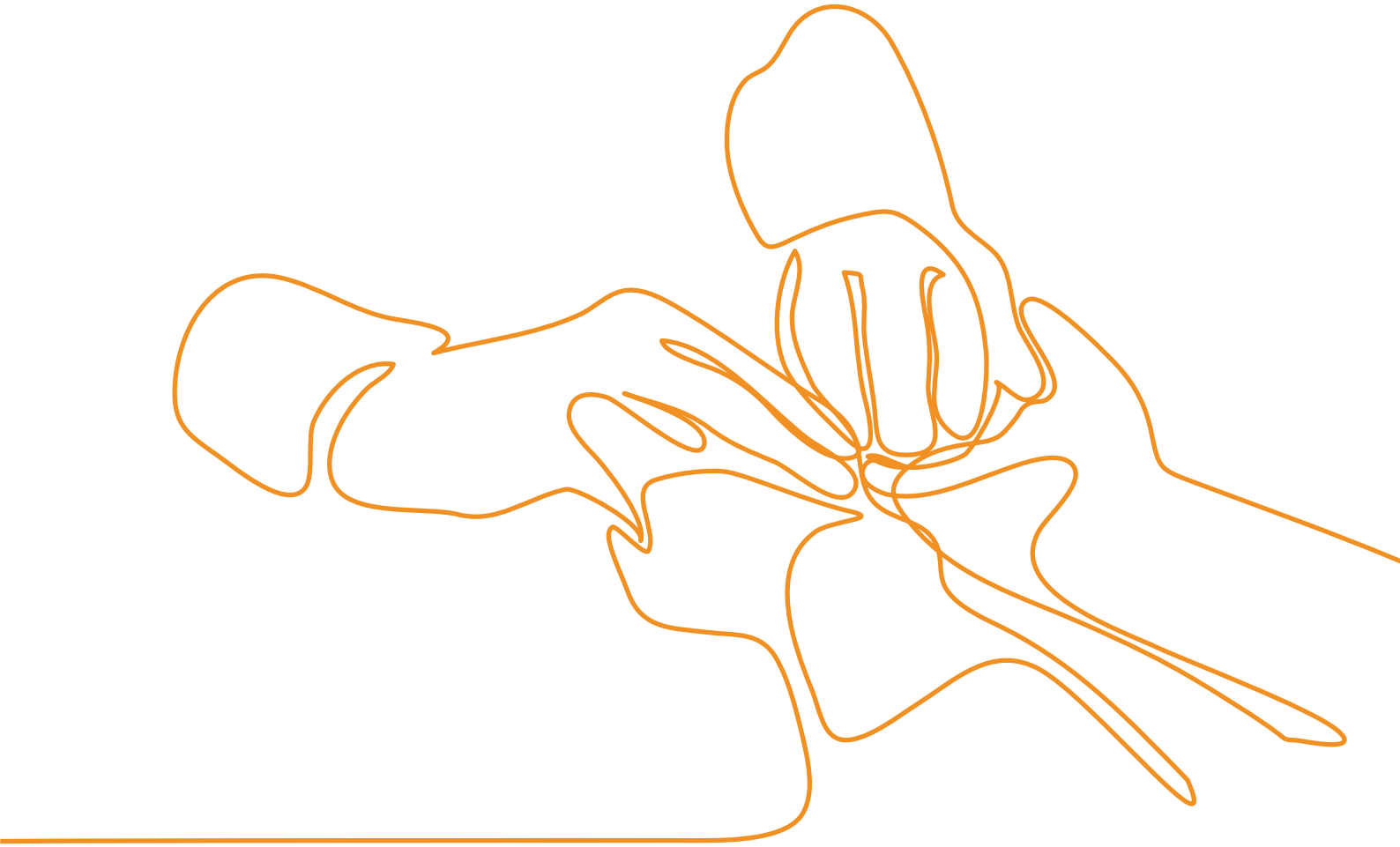
References from tables:

Page 54:

1. See here for further explanation: https://www.local.gov.uk/sites/default/files/documents/Technical%20Annex%20%281%29.pdf
2. See here for further explanation: https://www.local.gov.uk/sites/default/files/documents/Technical%20Annex%20%281%29.pdf
3. Our estimate of the cost uses Age UK figures as a starting point. We take their figure of 164,217 – the number of older people who receive no support with three or more essential daily activities – and assume support for those people based on the profile of existing support for older people in terms of home care and residential care. We then apply unit costs: for home care we cost 1 hour per day; for residential we cost a year of residential care.
4. We apply the same method used for estimating the cost of meeting unmet need amongst older people. However, as we do not have a starting number (equivalent to the Age UK figure of 164,217) we link to the number of working age adults currently receiving services. The number of working age adults supported is roughly 40 per cent of the number of older people supported so we apply that percentage to the Age UK figure and apply working age adult unit costs for home and residential care.
5. https://www.health.org.uk/sites/health/files/A-fork-in-the-road-Next-steps-for-social-care-funding-reform-0.pdf
6. As per under-pinning analysis conducted by the Health Foundation and King's Fund: https://www.health.org.uk/sites/health/files/A-fork-in-the-road-Next-steps-for-social-care-funding-reform-0.pdf
7. See for instance: https://www.health.org.uk/sites/health/files/A-fork-in-the-road-Next-steps-for-social-care-funding-reform-0.pdf and https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf
8. As per underpinning analysis conducted by the Health Foundation and King's Fund: https://www.health.org.uk/sites/health/files/A-fork-in-the-road-Next-steps-for-social-care-funding-reform-0.pdf

Page 58-59:

9. https://www.health.org.uk/sites/health/files/Social-care-funding-options-May-2018.pdf
10. We take the estimate as put forward by the Health Foundation and King's Fund (see 61) and uprate it by OBR forecasts for CPI inflation.
11. https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf
12. For illustrative purposes only, we take a figure of £1 billion and divide this by ONS projections for people aged 40+ in 2024/25. In practice there are many different ways to approach this option, and this cost illustration is intended to give an indication of likely average costs.
13. https://www.health.org.uk/sites/health/files/A-fork-in-the-road-Next-steps-for-social-care-funding-reform-0.pdf / https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf
14. For Income Tax estimates, we take the 2020/21 estimate as put forward by the King's Fund and Health Foundation, and uprate it on the basis of OBR forecasts of income tax take (themselves extended using the long term average rate of growth to get to 2024/25). In effect this is a 1p increase in the rate, not a 1 per cent increase in income.
15. https://www.kingsfund.org.uk/publications/how-nhs-performing-june-2018
16. For National Insurance, we take the 2020/21 estimate as put forward by the King's Fund and Health Foundation, and uprate it on the basis of OBR NIC revenue forecasts (themselves extended to get to 2024/25 as above). In effect this is a 1p increase in the rate, not a 1 per cent increase in income.
17. https://www.resolutionfoundation.org/app/uploads/2018/06/Healthy-Finances.pdf
18. We assume pensions rise with inflation.
19. Councils with responsibility for adult social care are only raising around £23 billion in council tax this financial year. 1 per cent of this is £230m. We uprate this in line with expected growth in council tax income so that we apply the 1 per cent to the expected tax base in 2024-25.
20. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Commission%20Final%20%20interactive.pdf



Local Government Association
18 Smith Square
London SW1P 3HZ

Telephone 020 7664 3000
Fax 020 7664 3030
Email info@local.gov.uk
www.local.gov.uk

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We consider requests on an individual basis.

REF 29.2

Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee – 4 September 2018

Subject: Overview Report

Report of: Governance and Scrutiny Support Unit

Summary

This report provides the following information:

- Recommendations Monitor
- Key Decisions
- Items for Information
- Work Programme

Recommendation

The Committee is invited to discuss the information provided and agree any changes to the work programme that are necessary.

Wards Affected: All

Contact Officers:

Name: Lee Walker
Position: Scrutiny Support Officer
Telephone: 0161 234 3376
E-mail: l.walker@manchester.gov.uk

Background document (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

None

1. Monitoring Previous Recommendations

This section of the report contains recommendations made by the Committee and responses to them indicating whether the recommendation will be implemented, and if it will be, how this will be done.

- There are no outstanding recommendations.

2. Key Decisions

The Council is required to publish details of key decisions that will be taken at least 28 days before the decision is due to be taken. Details of key decisions that are due to be taken are published on a monthly basis in the Register of Key Decisions.

A key decision, as defined in the Council's Constitution is an executive decision, which is likely:

- To result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates, or
- To be significant in terms of its effects on communities living or working in an area comprising two or more wards in the area of the city.

The Council Constitution defines 'significant' as being expenditure or savings (including the loss of income or capital receipts) in excess of £500k, providing that is not more than 10% of the gross operating expenditure for any budget heading in the in the Council's Revenue Budget Book, and subject to other defined exceptions.

An extract of the most recent Register of Key Decisions, published on 16 August 2018, containing details of the decisions under the Committee's remit is included below. This is to keep members informed of what decisions are being taken and, where appropriate, include in the work programme of the Committee.

Decisions that were taken before the publication of this report are marked *

Decision title	What is the decision?	Decision maker	Planned date of decision	Documents to be considered	Contact officer details
Cornish Close Scheme Ref: 2017/05/31B	Appointment of a support provider for the Cornish Close Scheme which includes 14 supported accommodation units over 5 properties, 6 short break beds.	Strategic Director of Adult Social Services	March 2018 or later	Report and Recommendation	Lesley Hilton-Duncan 0161 234 4419 lesley.hilton-duncan@manchester.gov.uk
Adult Social Care – Provider National Living Wage 2017/18 Fee Increase for Care Homes, Extra Care, Learning Disabilities and Mental Health services Ref: 2017/07/18E	Proposed increases are • 5% Care Homes • 3% Extra Care, LD and MH The increases proposed above when added to the previously agreed Homecare increases would be within the £4.26m allocated through the budget process.	City Treasurer	October 2018 or later	National Living Wage Briefing Note.	Michael Salmon 0161 234 4557 m.salmon@manchester.gov.uk
Review of adult social care commissioned services fees Ref: 2017/01/24B	To approve an update to fees for providers for implementation 2018/19.	Strategic Director of Adult Social Services	March 2018 or later	Report and recommendation	Lucy Makinson 0161 234 3430 l.makinson@manchester.gov.uk

Framework Agreement / Contract for the Provision of Homecare Services Ref: 2018/07/02B	The appointment of Providers to deliver Homecare Services	Executive Director Strategic Commissioning and Director of Adult Social Services	December 2018	Report and Recommendation	Mike Worsley Procurement Manager mike.worsley@manchester.gov.uk 0161 234 3080
Contract for the Provision of Advice Services 2018/08/16A	The appointment of a Provider to deliver Advice Services	Executive Director Strategic Commissioning and Director of Adult Social Services	November 2018	Report & Recommendation	Mike Worsley Procurement Manager mike.worsley@manchester.gov.uk 0161 234 3080
Contract for the Provision of Housing Related Support for Young People, Homelessness and Drug and Alcohol Services 2018/08/16B	The appointment of Provider to deliver	Executive Director Strategic Commissioning and Director of Adult Social Services	December 2018	Report & Recommendation	Mike Worsley Procurement Manager mike.worsley@manchester.gov.uk 0161 234 3080

Subject **Care Quality Commission (CQC) Reports**

Contact Officers Lee Walker, Scrutiny Support Unit
Tel: 0161 234 3376
Email: l.walker@manchester.gov.uk

Please find below reports provided by the CQC listing those organisations that have been inspected within Manchester since the Health Scrutiny Committee last met:

Provider	Address	Link to CQC report	Date	Types of Services	Rating
Sure Care (UK) Ltd	Brocklehurst Nursing Home 65 Cavendish Road Withington Manchester M20 1JG	https://www.cqc.org.uk/location/1-1333072984	6 July 2018	Nursing Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Good Well-led: Inadequate
Dr Nesar Choudhury	Brookdale Surgery 202 Droylsden Road Manchester M40 1NZ	https://www.cqc.org.uk/location/1-2890762581	6 July 2018	Doctors/GPs, NHS GP practice	**Overall: Inadequate** Safe: Inadequate Effective: Inadequate Caring: Inadequate Responsive: Inadequate Well-led: Inadequate

Allendale Rest Home	Allendale Residential Home Limited 53 Polefield Road Blackley Manchester M9 7EN	https://www.cqc.org.uk/location/1-145388961	10 July 2018	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well-led: Requires Improvement
BoJo Care Services Ltd	BoJo Care Services Ltd 808 Hyde Road Manchester M18 7JD	https://www.cqc.org.uk/location/1-1921056762	14 July 2018	Homecare agency	**Overall: Inadequate** Safe: Inadequate Effective: Inadequate Caring: Requires Improvement Responsive: Inadequate Well-led: Inadequate
Mr Michael Thomas Neville and Dr Asad Bokhari	The Neville Family Medical Centre 25 Old Market Street Blackley Manchester M9 8DX	https://www.cqc.org.uk/location/1-2538525894	10 July 2018	Doctors/GPs, NHS GP Practice	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good

Surrey Lodge Group Practice	Surrey Lodge Group Practice 11 Anson Road Victoria Park Manchester M14 5BY	https://www.cqc.org.uk/location/1-565594964	13 July 2018	Doctors/GPs, NHS GP Practice	**Overall: Good** Safe: Requires Improvement Effective: Good Caring: Good Responsive: Good Well-led: Good
Creative Support	Creative Support - Manchester Mental Health Services 6 Birch Grove Manchester M14 5JY	https://www.cqc.org.uk/location/1-3238141082	18 July 2018	Supported Living	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good
Westwood Homecare (North West) Ltd	Sedgeborough House 47 Sedgeborough Road Whalley Range Manchester M16 7EU	https://www.cqc.org.uk/location/1-654907849	17 July 2018	Homecare Agencies	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Good Well-led: Requires Improvement

The Seymour Home Ltd	Seymour Care Home 327 North Road Clayton Manchester M11 4NY	https://www.cqc.org.uk/location/1-118274983	17 July 2018	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Good Caring: Good Responsive: Requires Improvement Well-led: Requires Improvement
J J Bordiuk and M Bordiuk	Norlands Nursing Home Monsall Road Newton Heath Manchester M40 8NQ	https://www.cqc.org.uk/location/1-124645192	21 July 2018	Nursing Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well-led: Requires Improvement

Alness Lodge	Alness Lodge Limited 50 Alness Road Manchester M16 8HW	https://www.cqc.org.uk/location/1-224818147	21 July 2018	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well-led: Requires Improvement
The Regard Partnership	Homeleigh Middleton Road Crumpsall Manchester M8 4JX	https://www.cqc.org.uk/location/1-2670543973	26 July 2018	Residential Home	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good
Viewpark Care Home Limited	Viewpark Care Home Limited 685 Moston Lane Moston Manchester M40 5QD	https://www.cqc.org.uk/location/1-118097737	26 July 2018	Residential Home	**Overall: Inadequate** Safe: Inadequate Effective: Requires Improvement Caring: Requires Improvement Responsive: Requires Improvement Well-led: Inadequate

Mosaic Care Group Ltd	Fresh Fields Nursing Home Southmoor Road Wythenshawe Manchester M23 9NR	https://www.cqc.org.uk/location/1-1218789080	26 July 2018	Nursing Home	**Overall: Inadequate** Safe: Inadequate Effective: Inadequate Caring: Requires Improvement Responsive: Inadequate Well-led: Inadequate
Community Integrated Care	The Peele 15a Walney Road Benchill Wythenshawe Manchester M22 9TP	https://www.cqc.org.uk/location/1-1212453059	26 July 2018	Nursing Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Good Caring: Good Responsive: Requires Improvement Well-led: Inadequate
Alternative Futures Group Limited	Tesito House 2 Devonshire Street Manchester M12 4BB	https://www.cqc.org.uk/location/1-3512493436	24 July 2018	Hospitals - Mental health/capacity	**Overall: Inadequate** Safe: Inadequate Effective: Inadequate Caring: Requires Improvement Responsive: Requires Improvement Well-led: Inadequate

The Robert Darbishire Practice Limited	New Bank Health Centre 339 Stockport Road Manchester M12 4JE	https://www.cqc.org.uk/location/1-4355317290	6 August 2018	Doctors/GPs, NHS GP Practice	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good
Dr Ashraf Bakhat	Peel Hall Medical Practice Forum Health Simonsway Wythenshawe Manchester M22 5RX	https://www.cqc.org.uk/location/1-526710208	2 August 2018	Doctors/GPs, NHS GP Practice	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good
Belong Ltd	Belong Morris Feinmann 178 Palatine Road Manchester M20 2UW	https://www.cqc.org.uk/location/1-3924984564	8 August 2018	Homecare agencies, Nursing homes	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good
D R Price Associates Limited	Chataway Nursing Home 19-21 Chataway Road Crumpsall Manchester M8 5UU	https://www.cqc.org.uk/location/1-120005271	11 August 2018	Nursing homes	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good

Manchester City Council	Hall Lane Resource Centre (Respite Care, Short Breaks Service) 157-159 Hall Lane Baguley Manchester M23 1WD	https://www.cqc.org.uk/location/1-2146647956	9 August 2018	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well-led: Requires Improvement
CareBility Ltd	CareBility Piccadilly Business Centre Aldow Enterprise Park Blackett Street Manchester M12 6AE	https://www.cqc.org.uk/location/1-3823452441	9 August 2018	Homecare agencies	**Overall: Inadequate** Safe: Inadequate Effective: Requires Improvement Caring: Requires Improvement Responsive: Requires Improvement Well-led: Inadequate
The Robert Darbishire Practice Limited	New Bank Health Centre 339 Stockport Road Manchester M12 4JE	https://www.cqc.org.uk/location/1-4355317290	6 August 2018	Doctors/GPs, NHS GP Practice	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good

Longsight Medical Practice	Longsight Medical Practice 526-528 Stockport Road Manchester M13 0RR	https://www.cqc.org.uk/location/1-4648668416	10 August 2018	Doctors/GPs, NHS GP Practice	**Overall: Good** Safe: Good Effective: Good Caring: Good Responsive: Good Well-led: Good
Maybank House Ltd	Maybank House 588 Altrincham Road Brooklands Manchester M23 9JH	https://www.cqc.org.uk/location/1-115738956	15 August 2018	Residential Home	**Overall: Requires Improvement** Safe: Requires Improvement Effective: Requires Improvement Caring: Good Responsive: Requires Improvement Well-led: Requires Improvement

Health Scrutiny Committee
Work Programme – September 2018

Tuesday 4 September 2018, 10am (Report deadline Wednesday 22 August 2018) Please note deadline date due to Bank Holiday				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
New Models of Homecare Delivery	To receive a report on the new models of Homecare Delivery.	Cllr Craig	Carolyn Kus	
Public Health Annual Report (Air Quality)	To receive the Public Health Annual Report on Air Quality.	Cllr Craig	David Regan	
Local Government Association's green paper 'The lives we want to lead'	The Committee will receive the Local Government Association's green paper entitled 'The lives we want to lead' that was launched July 2018. The green paper seeks to lay the foundations to secure both immediate and long-term funding solutions for adult social care, as well as make the case for a shift in approach from acute treatment to community prevention.	Cllr Craig	Carolyn Kus	
Overview Report	The monthly report includes the recommendations monitor, relevant key decisions, the Committee's work programme and items for information. The report also contains additional information including details of those organisations that have been inspected by the Care Quality Commission (CQC) within Manchester since the Health Scrutiny Committee last met.		Lee Walker	

Tuesday 9 October 2018, 10am (Report deadline Thursday 27 September 2018)				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
Housing and Health	To receive an overarching report on Housing and Health. This report will provide the Committee with information on: Aids and Adaptions Service; Reablement and Physiotherapy Services; Housing options for older people; and Examples of work to address fuel poverty.	Cllr Craig Cllr Richards	Carolyn Kus Martin Oldfield Director of Housing	
Local Care Organisation – Progress report	To receive a progress report on the delivery of the Local Care Organisations. This report will include information on the delivery of the new models of care.	Cllr Craig	Professor Michael McCourt	
NHS Health Checks	To receive an update regarding NHS Health Checks. This report will include information on the Lung Health Check pilot scheme.	Cllr Craig	David Regan	
Overview Report			Lee Walker	

Tuesday 6 November 2018, 10am (Report deadline Thursday 25 October 2018)				
Item	Purpose	Lead Executive Member	Strategic Director/ Lead Officer	Comments
Personalisation and Empowerment -Prepayment Cards	To receive an update report on the introducing Prepaid Financial Cards. Prepaid Financial Cards (PFCs) are similar to a credit card where the adult social care agreed Personal Budget is loaded onto a card which is issued to the citizen.	Cllr Craig	Carolyn Kus Zoe Robertson	See minutes of November 2017. Ref: HSC/17/53
Overview Report			Lee Walker	

Items To be Scheduled				
Item	Purpose	Executive Member	Strategic Director/ Lead Officer	Comments
Autism Developments across Children and Adults	To receive an update report on Autism Developments across Children and Adults. This item was considered by the Health Scrutiny Committee at their January 2015 meeting.	Cllr Craig	Carolyn Kus	See minutes of January 2015. Ref: HSC/15/03 Invitation to be sent to the Chair of Children and Young People Scrutiny Committee.
Diabetes Care	To receive an update report on Diabetes care. This item was considered at the January 2015 Meeting of Health Scrutiny Committee.	Cllr Craig	Nick Gomm	See minutes of January 2015. Ref: HSC/15/03
NHS Health Checks	To receive an update regarding NHS Health Checks. This report will include information on the Lung Health Check pilot scheme.	Cllr Craig	David Regan	See minutes of July 2014. Ref: HSC/14/44
Update on the work of the Health and Social Care staff in the Neighbourhood Teams	To receive an update report describing the work of the Health and Social Care staff in the Neighbourhood Teams.	Cllr Craig	Carolyn Kus	
Manchester Health and Care Commissioning Strategy	To receive a report on the Commissioning Strategy for Health and Care in Manchester. The Committee had considered this item at their July 2017 meeting.	Cllr Craig	Carolyn Kus	See minutes of July 2017. Ref: HSC/17/31

Public Health and health outcomes	To receive a report that describes the role of Public Health and the wider determents of health outcomes.	Cllr Craig	David Regan	
Manchester Macmillan Local Authority Partnership	To receive a report on the Manchester Macmillan Local Authority Partnership. The scope of this report is to be agreed.	Cllr Craig	David Regan	See Health and Wellbeing Update report September 2017. Ref: HSC/17/40
Mental Health Grants Scheme – Evaluation	To receive a report on the evaluation of the Mental Health Grants Scheme. This grants programme is administered by MACC, Manchester's local voluntary and community sector support organisation, and has resulted in 13 (out of a total of 35) community and third sector organisations receiving investment to deliver projects which link with the Improving Access to Psychological Therapies (IAPT) services in the city.	Cllr Craig	Nick Gomm Professor Craig Harris	To be considered at the March 2019 meeting. See minutes of October 2017. Ref: HSC/17/47
Primary Care Access in Manchester	To receive an update report on access to Primary Medical Care in Manchester; both in core and also extended hours. Representatives from Healthwatch Manchester will be invited to attend this meeting.	Cllr Craig	Nick Gomm	Invitations to be sent to Vicky Szulist and Neil Walbran, Healthwatch Manchester. See minutes of February 2018. Ref: HSC/18/11
Care Homes	To receive a report that provides information on the provision of care homes in the city. The report will further describe the actions taken to respond to any findings of Inadequate or Requires Improvement following an inspection by the Care Quality Commission.	Cllr Craig	Carolyn Kus	See minutes of 17 July 2018. Ref: HSC/18/33
The Our Manchester	To receive an update report on the delivery of the Our Manchester Carers Strategy.	Cllr Craig	Carolyn Kus	See minutes of 17 July 2018.

Carers Strategy				Ref:HSC/18/31
Single Hospital Service progress report	To receive a bi-monthly update report on the delivery of the Single Hospital Service.	Cllr Craig	Peter Blythin, Director, Single Hospital Service Programme	See minutes of 17 July 2018. Ref:HSC/18/32