A case for sustainable funding for adult social care

LONDON COUNCILS

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Introduction

Adult social care is one of the largest spend areas for local authorities across the country. However, adult social care budgets have not kept pace with the growing demand for social care services. The Local Government Association[1] found that social care is absorbing a rising proportion of the resources available to councils. They estimate that spending on other council services will drop by 66 per cent in cash terms by the end of the decade, from £24.5 billion in 2010-11 to £8.4 billion in 2019/20 to accommodate the rising costs of adult care. This is the equivalent of an 80 per cent real terms cut.

Local authorities in London spend approximately 33 per cent (£2.8 billion) of their overall budgets on adult social care services and this is expected to increase as a result of demographic pressures. Demographic changes have been a key driver for reform in the sector. Demand in the adult social care sector is expected to increase over the coming years. It is projected that there will be an increase in demand among 18-64 year-olds with disabilities and also an increase in the very elderly as more people than ever are living beyond 85.

In London, the number of people aged 65 or over is expected to increase by nearly 50,000 between 2012 and 2017. Local authorities are already struggling to meet the needs of all those people who require social services intervention. Today, of 2 million older people in England with care-related needs nearly 800,000 receive no support of any kind from public or private sector agencies[2]. In light of the difficult economic climate, more people are likely to seek support who previously may have managed on their own leading to an increase in demand.

This report by London Councils and supported by Ernst and Young describes collaborative research undertaken to explore the scale of the funding pressures on adult social care and the extent to which these could be mitigated through achieving greater efficiencies in the way that social care is managed, procured and delivered.

The report uses examples of approaches where some boroughs are already achieving particular levels of savings and extrapolates them across other boroughs in London. It should be noted that if all boroughs in London were to implement these approaches, actual savings achieved would be subject to local circumstances and local decisions and would therefore vary.

The critical message to note in this report is that, despite the most optimistic potential savings being achieved by boroughs, the current funding gap in adult social care would still not be addressed without the government increasing borough funding allocations.

The funding gap in adult social care in London by 2017/18 is estimated to be at least £907 million.

1 Local Government Association (2012) Funding outlook for Councils from 2010/11 to 2019/20 – Preliminary Modelling http://www.local.gov.uk/c/document_library/get_file?uuid=c98405b7-b4a6-4b25-aebf-a63b5bcfa5c1&groupId=10171

2 AGE UK (2012) "Care in Crisis," http://www.ageuk.org.uk/Documents/EN-GB/Campaigns/care_in_crisis_2012_report.pdf?dtrk=true

Background

Local authorities, as the agencies with statutory responsibility for ensuring the provision of adult social care, have become increasingly concerned about rising demand for care and the associated increase in costs. In the last few years, this has been set against significant cuts (announced in the last spending review) to local government from central government in the order of 28 per cent over four years.

Despite considerable efforts and a number of reports over the years, most recently the work of the Dilnot Commission, agreement has not yet been reached as to the question of how adult social care should be paid for. At the same time, the current system has been criticised for its lack of fairness, complexity and fragmentation.

Our research

In this context, this research by London Councils and supported by Ernst and Young aimed to:

- Explore the current and future financial challenges that London boroughs face in meeting the social care needs of their adult population and the scale of the funding gap they will experience.
- Explore what options London boroughs might have for improving both efficiency and outcomes in adult social care in the context of constrained financial resources and extensive pressures on council budgets.
- Draw on findings from London Councils' own research on the costs of implementing the main Dilnot Commission recommendations in London to explore what impact this would have on the size of the funding gap.

The research involved a range of methods including: a workshop with senior representatives from London Borough adult social care departments, a survey of all London Directors of Adult Social Services, face to face interviews with a small number of Adult Services directors, and detailed financial modelling.

Responding to increased financial pressures in adult social care

Through the above research, four main options were identified as potentially offering the most opportunities for local authority social care departments to achieve additional savings. Further analysis was then undertaken to identify the current state of development in these areas, any notable case studies, barriers and lessons learnt and the scale of potential savings for London that could be realised.

Health and social care integration

This requires both the health sector and local government to approach care and health in a holistic way and to change the way that they work to achieve better alignment of services and support. The results would not only achieve significant savings but also a better experience for service users too.

Range of potential savings for London: £125 million – £375 million by 2017/18

Implementation of alternative delivery models

This option concerns the establishment of Local Authority Trading Companies or social enterprises as an alternative to in-house provision of adult social care services.

Range of potential savings for London: £70 million – £220 million by 2017/18

Category management

This option involves local authorities moving towards a more systematic and disciplined approach to the procurement of goods or services.

Range of potential savings for London: £45 million – £140 million by 2017/18

Public Health

This option involves local authorities using their new responsibilities for public health to improve the health of communities and prevent or delay need for both care services and health services. It is too early at this stage to estimate potential savings that could be achieved from increased investment in public health. It is important to note that savings will only be possible if the funding made available to local

authorities match the responsibilities that are being transferred. Based on historical allocations this is not the case for all councils.

What is the potential overall saving from implementation of the above options?

Based on the financial modelling carried out for this research, there is the potential for London local authorities to save between **£240 million and £735 million** from implementing integration in health and social care, alternative delivery models and category management, with additional longer-term savings anticipated from increased investment in public health.

However, the ability of councils to achieve these savings is dependent on government policy decisions and also on the extent of demographic pressures.**Not all of the four options above will be appropriate for every local authority and the savings attained will vary across London.** The projected figures illustrated in this report therefore provide only an indication of what could be achieved.

The scale of the funding gap even if the above savings are achievable

A key finding of this research is that even if councils were to maximise the savings that they can achieve over the next few years, this is unlikely to bridge the funding gap in the sector, which is likely to continue growing. This report finds that the only way this funding gap could be completely bridged would be through a change to the levels of funding allocated from government to councils or through reforming how adult social care is funded.

What can government do to support local authorities to meet their adult social care commitments?

Financial Support

The recommendations put forward by the Dilnot Commission are not a complete solution to addressing the funding pressures currently being experienced by councils in the commissioning and delivery of adult social care in London. Indeed this was not the question set for the Dilnot Commission, which was asked to explore fairer mechanisms for funding rather than bridging a funding gap. Government needs to make more of a commitment to increasing funding to the sector, in the following ways:

1. In the absence of the Dilnot recommendations being implemented and the assumption that local authorities are able to achieve maximum savings, government would still need to increase adult social care budgets to London councils. This could potentially be as high as £1.1 billion if the next CSR budget cuts are as high as 15 per cent and no savings are made by local authorities. (It is important to note that the impact of the Dilnot Commission's proposals is not included in the calculation of this funding gap).
2. If the Dilnot recommendations were to be implemented and with estimated 15 per cent budgets cuts, a minimum of at least £1.5 billion additional funding would be required to enable local authorities in London to meet the proposals put forward by the Dilnot Commission and also meet the funding gap.

Other ways that government can support local authorities

Government should maximise the opportunities for local authorities to pursue the four options for achieving savings identified above by:

3. Driving forwards a change in data protection regulations that will enable adult social services and their health partners to share information more easily regarding service users.
4. Creating policies that enable an increase in multidisciplinary working across both health and adult social care.
5. Removing tariff based payment models in the acute sector that are activity based with little incentive to reduce activity by acute trusts through investment in integrated community services.
6. Encouraging the NHS and local government to focus on positive outcomes for patients and service users and to move away from focussing on targets and tariffs.
7. Looking at how the process for local authorities to implement alternative delivery models could be

simplified and made less expensive, particularly with regards to tax liability.

8. Setting funding for public health to local government at appropriate levels to meet local needs. Furthermore, government should ensure that the requirements for the funding to be ring-fenced should still enable local authorities maximum flexibility in terms of how they are able to use the grant to meet local needs.

What changes are required in how local authorities work to enable them to maximise their potential savings?

Local authorities are already exploring different ways of delivering and commissioning adult social care services. In all likelihood, funding pressures over the coming years are likely to worsen and the age profile of the population will continue to get older. Local government needs to position itself to meet this challenge and the following are potential ways that local authorities could do this:

1. Local authorities need to be in close discussion and engagement with key partners particularly the NHS. If potential savings from collaboration and integration between health and social care are to be realised, on-going dialogue is essential.
2. Local authorities need to work with the NHS particularly GPs and other key partners to ensure that information is available and shared across the sector. GPs could play a critical role in sign posting to community based services.
3. Local authorities need to begin to explore the benefits in implementing alternative delivery models. To optimise the benefits, local authorities need to consider working with other local authorities possibly sub-regionally (over-coming political differences) to enable them to achieve scale and critical mass as this is critical to success and the potential savings that can be achieved.

Conclusion

It is evident that the funding pressures facing adult social care in London are significant and will only intensify over the next few years. The failure of successive governments to find a long-term solution to the question of how to pay for adult care has left local government increasingly struggling to meet the care needs of older adults and adults with disabilities with diminishing resources.

This report shows that there are a number of potential options still open to local authorities to explore in order to achieve savings while maintaining or increasing outcomes for service users. However, it also shows that even if it were possible to exploit the savings from each option to the full, there would still be a funding gap in adult social care.

It is therefore imperative that government not only supports local government to develop options such as the ones above, but that it also renews its efforts to find a sustainable and fair solution to ensure that there is adequate funding for adult social care over the longer-term.

↘02 introduction

This report by London Councils and supported by Ernst and Young describes collaborative research undertaken to explore the scale of the funding pressures on adult social care and the extent to which these could be mitigated through achieving greater efficiencies in the way that social care is managed, procured and delivered.

The report uses examples where some boroughs are already achieving particular levels of savings and extrapolates them across other boroughs in London. The examples used also offer potential approaches that could be used by boroughs to achieve some savings. It should be noted that actual savings achieved would be subject to local circumstances and local decisions and would therefore vary.

The funding gap by 2017/18 is estimated to be as high as £907 million.

The question of how to and who should pay for the care of older and disabled people has vexed policy makers, campaign groups, services users themselves and others over the last few decades.

Unlike health care, which except in certain circumstances is generally free at the point of delivery, social care is subject to a means-test and frequently an individual contribution.

Local authorities, as the agencies with statutory responsibility for ensuring the provision of adult social care for those who need it, have become increasingly concerned about rising demand for care accompanied by increasing costs. In the last couple of years, this has been set against significant cuts to local government from central government in the order of 28 per cent over four years.

Previous research for London Councils has found that the net budget requirement for adult social care in London boroughs accounts for approximately a third of the total council budget and is even higher in some authorities. Recent analysis from a London borough[3] shows the potential for spend on adults' and children's services to completely overwhelm local authority budgets around 2020, emphasising the scale of this as an issue.

Demand for care is expected to continue to rise as a result of demographic changes - most notably growing numbers of very elderly people - the rising incidence of life-limiting chronic conditions, including dementia, and increasing numbers of children and young people with complex health needs who are expected to survive into adulthood.

In July 2010, the government commissioned Andrew Dilnot, to review the funding system for care and support in England. In July 2011, the Dilnot Commission reported[4] back to government, and made its recommendations for reforming the rules for funding adult social care. Among its recommendations are a cap on individual life time costs for care, an increase in the upper limit of the means-test threshold, above which individuals are liable for their full care costs, from £23,500 to £100,000 and an assumption that children becoming adults with an

3 Guardian (2012) *"Graph of Doom: a bleak future for social care services."* Guardian article http://www.guardian.co.uk/society/2012/may/15/graph-doom-social-care-services-barnet

4 Dilnot Commission (2011) *"Fairer Care Funding – The report of the Commission on the funding of care and support."* https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf

identified social care need have met the lifetime cap and should not be means-tested.

The white paper[5] on social care and the government's response to the Dilnot Commission were published in July 2012 and did not produce the answers on long-term funding that many hoped they would include. Instead, government committed simply to consider the issue of long-term funding of social care within the next spending review in 2015/16.

More recently, there have been signals from inside government that there is a willingness to explore some of the Dilnot Commission's recommendations including the cap on lifetime contributions. However, there are less well heard concerns that implementing Dilnot alone may not improve the financial position of boroughs responsible for providing social care services.

It is in this context that London Councils carried out research supported by Ernst & Young to produce this report. The aims of the work were:

- To explore the current and future financial challenges that London boroughs face in meeting the social care needs of their adult population and the funding gap.
- To explore what options boroughs might have for improving both efficiency and outcomes in adult social care within the context of constrained financial resources and extensive pressures on council budgets.
- To bring in findings from London Councils' own research on the costs of implementing the main Dilnot Commission recommendations in London.

The project used several different methods as outlined below:

- Workshop – Directors of Adult Services and other representatives from adult services departments were invited to attend a workshop which was facilitated by Ernst & Young and London Councils. The purpose of the workshop was to explore some of the main issues that adult services departments were faced with and to explore how councils were responding/could be responding to the financial pressures in the sector.
- Survey – Following the workshop a survey was sent to all Directors of Adult Social Services to build on the workshop and to also enable additional information on local demands and pressures to be included in the research.
- Face-to-face interviews – were also held with a small sample of Directors of Adult Social Services to enable in-depth discussions exploring specific local demands.
- Financial Modelling – London Councils carried out some financial modelling using current demographic trends to explore potential future pressures and savings that could be achieved in the sector. The financial model had three main elements to it:
  - The first compared demographic trends based on the Greater London Authority's projections with local authority Personal Social Services returns going back to 2003/04.
  - The second estimated funding gap projections were based on 28 per cent budget cuts[6] announced in the comprehensive spending review. An additional 5 per cent, 10 per cent and 15 per cent from 2015/16 when the next CSR is expected was factored in.
  - The third estimated potential savings that could be attained from implementing health and social care integration, alternative delivery models and category management. The model used case studies and assumed that if they could be replicated across London similar savings could be attained but also explored a range of potential savings that could be attained at 50 per cent more and 50 per cent less than the case study so that a broad range of potential savings could be explored allowing for the impact of local decisions and local circumstances.

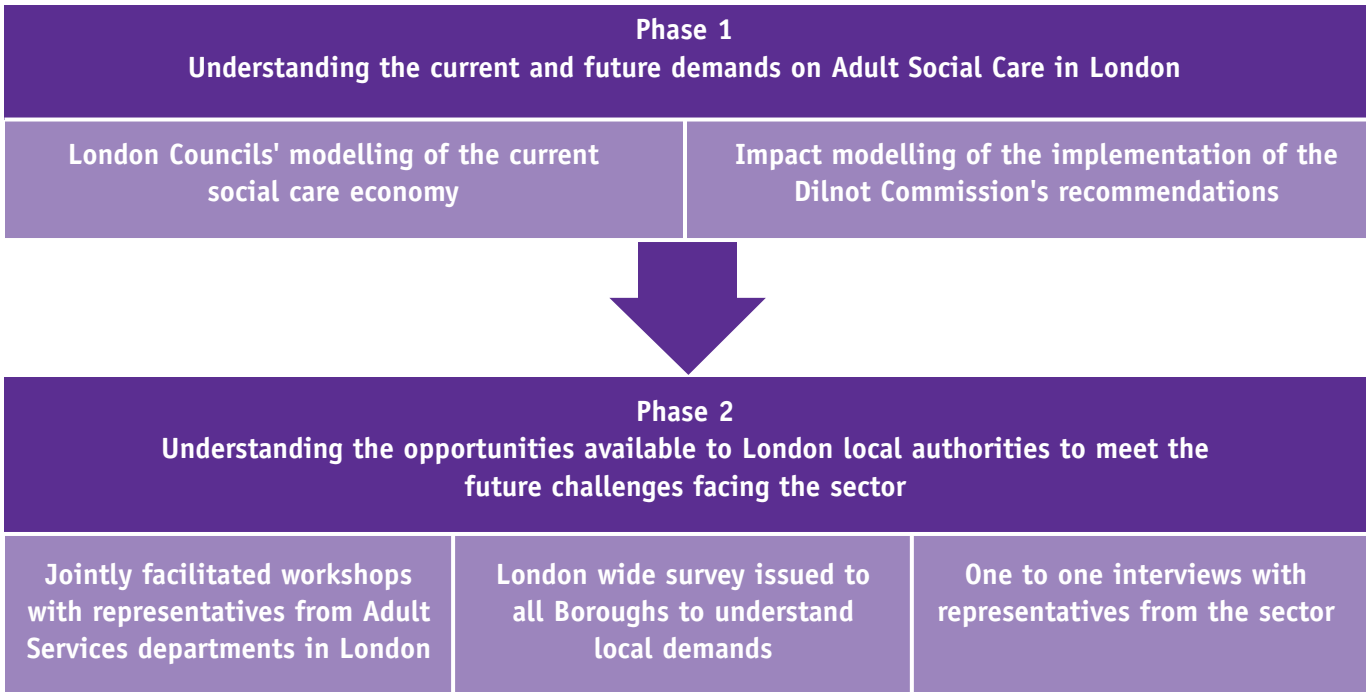
5 Department of Health (2012) *"Caring for our future reforming care and support white paper."* http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper/

6 Because government funding is largely not ring-fenced, there is difficulty in arriving at an estimate of how the exact proportion of cuts borne by adult social care departments as such the overall 25 per cent cut applied to authority has been applied across for the periods 2011/2015.

- No estimates were made for the public health funding option as it is too early in the transfer of public health funding to local authorities therefore there were no case studies that could be used.

Figure 1 below summarises the methodology that was used.

Figure 1: **Summary of methodology used**



This report is intended to provide a contribution to current discussions and debates regarding the future of adult social care and how local authorities can meet the funding pressures that they are faced with. It considers several options that boroughs should consider implementing to help them mitigate these financial circumstances. The report also demonstrates that government needs to commit to a long-term sustainable funding if it is to ensure that all who need it are able to draw on good quality social care package.

↘03 policy background

Policy and fiscal context - the current system

The Social Care Institute[7] define social care as; 'all interventions provided or funded by statutory and/or independent agencies which support older people, younger adults and children in their daily lives, and provide services which they are unable to provide for themselves, or which it is not possible for family members to provide without additional support'.

Every year, nearly two million[8] adults in England use social care services commissioned or provided by their local council. Local authorities are key agents in the delivery of adult social care services as they have legal responsibilities set out in the National Assistance act 1948 to provide support and care to vulnerable adults.

However, unlike services from the National Health Service (NHS) which are free at the point of need, adult social care is subject to both needs assessment and means-testing.

A needs assessment is carried out by a local authority to determine the level of risk a person has. The local authority uses an assessment process called fair access to care services (FACS). FACS has four basic levels, or bands, of care - low, moderate, substantial and critical. In recent years, most London boroughs have moved to only providing services for those individuals who are found to have substantial or critical levels of risk. Given the funding pressures, a number of local authorities are now seriously considering moving only to the critical level of risk.

Individuals also have a means-test of their financial resources to determine how much they will be asked to contribute to the costs of their care and how much financial support they will receive from the local authority. If they have savings and resources of more than £23,250 then they will have to pay the full costs of their care at home. When residential care is needed the value of the home is also included in this financial assessment (with the exception of those cases where there may be another relative still living in the house).

Challenges Facing the Sector

Financial Pressure

Adult social care is one of the largest spend areas for local authorities across the country. However, adult social care budgets have not kept pace with the growing demand for social care services. The Local Government Association[9] found that social care is absorbing a rising proportion of the resources available to councils. Nationally the LGA estimates that spending on other council services will drop by 66 per cent in cash terms by the end of the decade, from £24.5 billion in 2010-11 to £8.4 billion in 2019/20 to accommodate the rising costs of adult care. This is the equivalent of an 80 per cent real terms cut.

Local authorities in London spend approximately 33 per cent (£2.8 billion) of their overall budgets on adult social care services and this is expected to increase as a result of demographic pressures.

7 Waine B, Tunstill. J; Meadows. P; and Peel. M. (2005) *"Developing social care values and principles."* Social Care Institute http://www.scie.org.uk/publications/positionpapers/pp04/values.pdf

8 House of Commons (2010) Social Care Health Committee http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/22/2204.htm

9 Local Government Association (2012) Funding outlook for Councils from 2010/11 to 2019/20 – Preliminary Modelling http://www.local.gov.uk/c/document_library/get_file?uuid=c98405b7-b4a6-4b25-aebf-a63b5bcfa5c1&groupId=10171

In London, it is estimated that by 2020, the principal statutory responsibilities of local government – namely social care and waste – could require over 60 per cent of all available resources. Given their statutory nature, these costs are, to a certain extent, unavoidable, suggesting that local authorities are facing a considerable loss of financial flexibility and control over their discretionary spending decisions as they spend more on their statutory responsibilities (see figure 2 below).

Figure 2: **Reduction in funding**

	Reduction in Funding: 2012/13 to 2019/20 £M	**Reduction in Funding: 2012/13 to 2019/20 %**
Central Services	-317	-57%
Capital financing and all other costs	-625	-45%
Highways, Roads and Transport	-147	-44%
Culture, Recreation and Sport	-189	-41%
Education (exc. Schools)	-311	-35%
Housing	-216	-35%
Other environmental & regulatory services (Environmental spend excluding waste management)	-236	-35%
Planning and Development	-24	-14%
Total non-protected services	**-2,065**	**-41%**

Potential impact on local authority non-protected services[10]

The past five years have seen a shift in government policy towards greater personalisation in adult social care which is likely to add to the financial pressure faced by councils in delivering services.

The aim of personalisation is to give greater autonomy to people to enable them to determine how money allocated to meet their needs should be used. While this is a positive move aimed at empowering service users, it is likely to have implications on overall services provided by councils. As the number of personal budgets increase, it may have the effect of reducing the local authority's ability to continue to provide certain services that have in the past been taken as standard. Increasingly local authorities may find that they need to either start to charge for services that were previously free or to cut back some services. To avoid this happening, local authorities need to have adequate funding allocations to enable them to fully support the personalisation agenda while also enabling them to continue to offer other care services.

10 London councils research (2012) Resourcing London : Financial Prospects for London Local Government - 2020 Vision - London Finance Commissionhttp://www.londoncouncils.gov.uk/committees/agenda.htm?pk_agenda_items=5104

Demographic changes

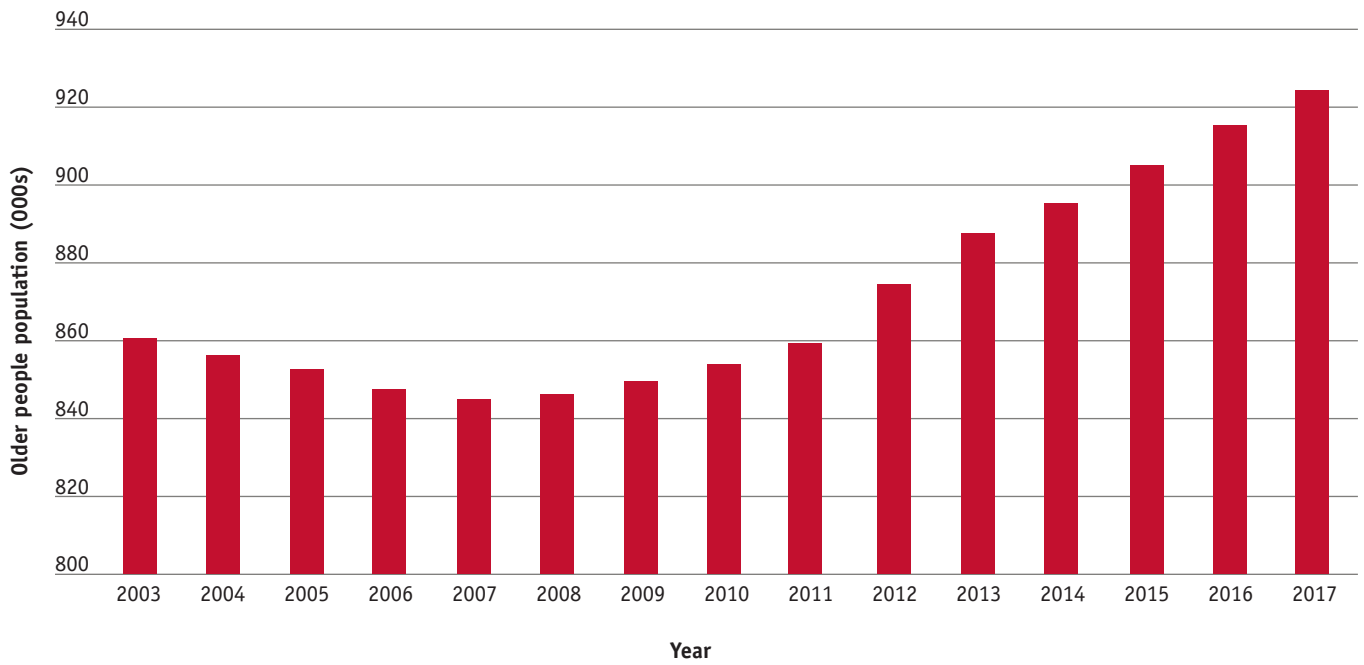
Demographic changes have been a key driver for reform in the sector. Demand in the adult social care sector is expected to increase over the coming years. It is projected that there will be an increase in demand among 18-64 year olds with disabilities and also an increase in the very elderly as more people than ever are living beyond 85.

In London, the biggest demographic pressure in adult social care is expected to be in the growth in number of young adults with learning disabilities. Figure 3 below illustrates the differences in the expected growth among young adults with learning disabilities by 2030 in England and in London.

In London the number of people aged 65 or older is expected to increase by nearly 50 000 between 2012 and 2017 (as illustrated in figure 4 over). Local authorities are already struggling to meet the needs of people who require social services intervention and an estimated 800,000 older people do not draw on services that they would be entitled to receive. In light of the difficult economic climate, more people are likely to seek support who previously may have managed on their own leading to an increase in demand.

Figure 3: **Growth index - Young adults with learning disabilities**

Figure 4: **Projection of people 65 years and older**



The working age population as a share of the total population in the United Kingdom is expected to shrink from 66 per cent in 2010 to 61 per cent in 2030[11] which will have an impact on the revenue from taxation. This is likely to put additional pressure on the funding available to local authorities for adult services.

Additional demographic changes are also expected as a result of continued breakdown in traditional family structures. This is likely to result in a reduction in the number of older people who are taken care of by their family members, thereby increasing the demand on services provided by local authorities, including traditional homecare and costly residential care. All these factors will contribute to adding pressure on adult social care sector.

Criticisms of the current system

In addition to the financial pressures and demographic changes the current system also has some systemic challenges that have resulted in increased calls for the whole social care system to be updated, to make it less unfair and less fragmented.

An unfair system

Many advocates for adult social care have argued that the current system is unfair as state support is distributed inequitably and is not a reflection of contributions made by individuals and families throughout their working lives.

The system is seen to be unfair on several different levels:

- State support is not provided for those with savings above a certain level.
- As the pressure on resources increases state funded support and care is often only provided when people have already developed high levels of need. There have been calls for more investment in prevention as although this would require greater up-front spending it should result in long-term savings.
- In some cases people with similar needs receive different levels of support packages depending on where they live.

11 OECD (2011) *Help Wanted? Providing and paying for long-term care.* OECD Publishing http://www.oecd.org/health/healthpoliciesanddata/47890836.pdf

A fragmented system

The adult social care system has often been criticised for being too fragmented and requiring greater integration with other welfare services such as housing, health and the benefits system.

The current system has placed responsibility for joining up care on the individuals themselves, reform is needed for this responsibility to be on the commissioners and providers of welfare services to ensure that they offer services in an integrated way.

All these challenges have resulted in repeated calls for reforming the adult social care system so that it becomes fairer placing independence, self-determination and wellbeing at the heart of any reforms.

Policy responses

Policy Reform Background

To fully understand the problems facing the adult social care sector there is also a need to understand its policy context. The origins of current social care policy can be traced to the 1948 National Assistance Act. The Act set out in broad terms what the local authority's responsibilities should be with regards to residential accommodation. Since 1948, there have been attempts nearly every decade taken by successive governments to try and update the system.

By the 1950s, there was a shift towards a preference for keeping people in their homes rather than residential accommodation. This was driven largely by financial concerns and the poor quality of life offered in residential accommodation. Local authority responsibilities began to broaden as community care increased.

Since the 1970s, several attempts have been made to introduce policies that would result in better alignment and coordination between health and social care. 1971 saw the creation of integrated social services departments shortly followed by the reorganisation of the health service in 1974 which served to move many services out of local government control and into the NHS. Attempts to improve the coherence of health services were arguably at the price of creating further barriers, gaps and overlaps with local authority social services[12].

Through the 1980s to date, there have been several commissions and attempts to address the problems faced by adult social care particularly the financial concerns. In 1988, Sir Roy Griffiths was tasked with investigating a way forward for community care which was followed by the publication of a white paper – *Caring for People*. In 1999, the government set up the Royal Commission on long-term care which explored who should fund long-term care. In 2009, the government published a green paper, Shaping the Future of Care Together, which explored the development of a fairer national care service. Despite these reviews there has been little change made to adult social care funding.

Decades after the Royal Commission on long-term care, the coalition government has stated that it is committed to reforming the adult social care sector and, since the 2010 general election, has carried out a listening and engagement exercise, commissioned the Law Commission to review and put forward recommendations for reforming adult social care law, and commissioned the Dilnot Commission to review the future funding of adult social care. In July 2012, the government published a white paper - Caring for our future: reforming care and support and a Draft Care and Support Bill. The Law and Dilnot Commissions are explored in greater detail below.

Law Commission

In 2011, the Law Commission completed a review of the legislation and law on social care. The review recommended bringing together all the different elements of social care law currently covered by 40 separate statutes into a single, adult social care statute, making it easier to understand and potentially prevent any unnecessary court cases. Among the Commission's recommendations were the following:

- Putting the individual's wellbeing at the heart of decision-making, using new statutory principles.

12 Hudson B and Henwood M (2002) The NHS and social care; the final countdown? *Policy and Politics*. 30(2): 153–66.

- Giving carers new legal rights to services.
- Placing duties on councils and the NHS to work together.
- Building a single, streamlined assessment and eligibility framework.
- Protecting service users from abuse and neglect with a new legal framework.
- For the first time, giving adult safeguarding boards a statutory footing.

The Dilnot Commission

In July 2010, the Dilnot Commission was launched and tasked with examining the future demands likely to face the sector and how to achieve an affordable and sustainable funding system for care and support for all adults in England, both in their own homes and other care settings. The Commission was specifically tasked with exploring how:

- Best to meet the costs of care and support as a partnership between individuals and the state.
- People could choose to protect their assets, especially their homes, against the cost of care.
- Public funding for the care and support system can be best used both now and in the future, to meet care and support needs.
- Any option can be delivered, including an indication of the timescale for implementation, and its impact on local government (and the local government finance system), the NHS, and – if appropriate – financial regulation.

In carrying out their review of adult social care, the Dilnot Commission identified some of the problems facing the sector.

Rising Costs

The Commission identified the high cost of care as a serious problem. They estimated that at least 1 in 10 people at age 65 would face a life time care costs exceeding £100,000. Furthermore, due to rising costs facing adult social care, the sector is now largely inadequately funded which has resulted in people not receiving the care and support that they need.

Inconsistent Services

The Commission also found that the care system delivers inconsistent services to people and that there is an unacceptable variation in eligibility for services across the country. They also argued that it was a disadvantage to people to not have access to portable assessments that would encourage them to move around more easily.

Complexity of the system

The current system is complex and difficult to understand. People do not understand or know how much care and support they may need, nor do they understand the associated costs. Therefore, they are unable to plan for their future care and support needs. Many people believe they will receive free care when they need it and usually only discover the scale of their financial liabilities at the point that they, or a family member, need care or support.

Additionally, there is inadequate information available to enable people to make the right decisions regarding their care and this is worsened by the fact that the system is disjointed with service users often having to approach different departments and organisations for support.

Recommendations from the Dilnot Commission

The Dilnot Commission launched its report in July 2011. It stated that the government's requirement had been met and that the system they were proposing would redefine the contract between the state and the individual and had the following characteristics:

- Choice: offering an affordable choice to individuals, carers and families across a range of care settings, and helping people to plan and prepare for the future.
- Fairness: for individuals, families, carers and wider society.
- Value for money: securing the highest quality care outcomes with the available resources.
- Sustainability: ensuring that the costs to the state are sustainable in the context of an ageing population.

Key features of the care system proposed by the Dilnot Commission are set out in figure 5 below.

Figure 5: **Dilnot Commissions proposals for a new care system (The report of the Commission on Funding of Care and support (2011, pp.21)**

To enable this system to work, the Commission put forward the following key recommendations[13]:

- Individuals' lifetime contributions towards their social care costs – which are currently potentially unlimited – should be capped. After the cap is reached, individuals would be eligible for full state support. This cap should be between £25,000 and £50,000. We consider that £35,000 is the most appropriate and fair figure.
- The means-tested threshold, above which people are liable for their full care costs, should be increased from £23,250 to £100,000.
- National eligibility criteria and portable assessments should be introduced to ensure greater consistency.
- All those who enter adulthood with a care and support need should be eligible for free state support immediately rather than being subjected to a means-test.

Response to the Dilnot Commission's proposals by the sector

When the Commission's proposals were put forward they were generally accepted and hailed by the sector as a positive step forward for addressing some of the significant problems in the sector.

However, the Commission's proposals set out one big challenge for government; with a price tag of at least £1.7 billion in the first year of implementation and the government's own estimates that the proposals would result in an increase in public expenditure from 0.15 per cent to 0.30 per cent of GDP by 2025/26, the government has been reluctant to commit to them.

While generally welcoming the Dilnot Commission's proposals, other suggestions have also been put forward by the LGA and the Department of Health for alleviating the costs of implementing the Dilnot recommendations. These include:

- Increasing the lifetime contributions cap – the LGA has suggested it should be increased to £50,000

13 To see all 10 recommendations by the Dilnot Commission see the full report at https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf

and not £35,000 or even higher to £60,000 as suggested by the Department of Health.

- A lower means-testing threshold than £100,000.
- Encouraging people to save more towards their future care needs.
- Harnessing the private sector to play a bigger role in helping people to save for their future care needs.

In addition to these suggestions, there is also is a general recognition in the sector that if the issue of long-term funding is to be fully addressed then there needs to be buy-in from different stakeholders to ease the burden on the public pocket. This is required from the following:

- The public: there is need for everyone to prepare proactively for funding their future social care needs. To do this public awareness must be raised to ensure increased knowledge about how adult social care is funded and how best they can meet the cost of their own care requirements.
- The private sector: traditionally the private sector has played a minimal role in funding adult social care or offering financial packages that would help people to be more prepared for their care needs. The private sector now needs to play a more proactive role in offering products to encourage people to save for their future.
- Central government: successful implementation of the Dilnot Commission's recommendations requires commitment from government to increasing the funding it makes available to the sector. Without the treasury committing to meet the required increase, the Dilnot Commission's proposals cannot be implemented.
- Local government: Local authorities need to work closely with government and providers, ensuring that funding made available is optimally used and that social care needs of vulnerable people are fully addressed.

Despite ongoing calls from various sections of the adult social care sector for the government to commit to the Commission's proposals and the long-term funding of adult social care, the government has not done so. The government has to date refused to commit to the key recommendations put forward by the Dilnot Commission arguing that they are too expensive particularly in the current economic climate.

Implications of the Commission's recommendations for London

While recognising that government has not yet committed to implementing the Dilnot Commission's recommendations, as part of this project, London Councils has carried out research focusing on the possible impact on London's social care spending if some of the Commission's recommendations were to be implemented. London Councils focused specifically on three recommendations which if implemented would have a big impact on the future funding of adult social care. These are:

- The means-testing threshold increased,
- A life time contribution cap introduced and;
- Provision of free care and support to children becoming adults with a social care need.

Increasing the means-testing threshold

London Councils research found that the biggest jump in adult social care spending as a result of increasing the threshold would occur in the first year of implementation when the largest numbers of people receiving care who are currently ineligible because they have resources more than the current level of £23,250 then become eligible for support. Following the first year this number would stabilise as then it would just be the new service users newly entering the system.

The research found that setting the means-testing threshold at a £100,000, a minimum of an additional £286 million in the first year could be spent by local authorities and by the fifth year an additional £413 million more might have been spent compared to what local authorities are currently spending.

Introduction of a life time cap

The Dilnot Commission reported that it is unfair for people to continue to pay for their care without a limit being put in place, and that this effectively discourages people from saving for their care because they do not have a target to save. The Commission

recommended that there needs to be a limit set that people should have to pay after which the state would pay for their care.

London Councils' research found that introducing a life time contribution cap would increase local authority spend in London by £112 million in the first year of implementation. The cost of introducing a life time cap at £35,000 could potentially be over half a billion pounds (£537 million) by the fifth year of implementation.

Setting a higher life time contribution cap would result in less pressure on the public purse. The LGA has been advocating for setting the cap at £50,000. While the government in its progress report on funding continuously uses the example of a £75,000 cap no announcement has been made as to whether a life time contribution cap will be introduced, nor what that cap would be if it is to be introduced.

Free care and support to children becoming adults with a social care need

Currently any child who turns 18 and has an existing care need has to be reassessed by adult care services. The Dilnot Commission found this to be unfair and recommended that any young person turning 18 with an existing care need should no longer have to be reassessed but should be deemed to have already met their life time cap contribution and therefore should receive free care from the local authority.

However, local authorities already provide ongoing care to the majority of children becoming adults with an existing care need as they often do not have their own resources and therefore this proposal will have minimal impact on the future funding of adult social care.

What does this mean for London?

Due to some specific London factors, such as higher housing costs and higher costs of residential care as a result of local differences such as wages, spending on adult social care in London in 2010-11 was nearly 17 per cent above the national local authority spend on adult social care.

London Councils' research shows that if all the Commission's proposals were implemented London would require an increase of 11.4 per cent in the first year of implementation from the current £2.8 billion spend on adult social care to £3.16 billion. This would increase to £3.44 billion by the fifth year representing an increase of 21.3 per cent above current spending levels – equating to on average, a £19 million increase per borough in London (potential impact of the comprehensive spending review not included in this figure see figure 11 for impact of the CSR).

While the Dilnot Commission's recommendations have been applauded as the most viable way forward, and have been embraced by the majority in the sector, it is important to note that they do not go far enough if the current financial pressures in the sector are to be addressed.

Although the recommendations made by the Commission would offer relief to the thousands of self funders who have no clarity on how much they are likely to need to pay towards their own care needs, they do not offer a solution for how the on-going financial pressures in delivering adult social care for those people requiring local authority support can be eased. Alternative solutions therefore need to be explored that will address this gap.

Draft Care and Support bill and White Paper 2012

In July 2012, the government brought together some of the recommendations put forward by the Law Commission and the Dilnot Commission in the Draft Care and Support Bill which was published alongside a white paper, Caring for our future: reforming care and support.

This white paper sets out the government's vision for a reformed care and support system. The proposals set out in these policy documents aim to reform the sector so that some of the current problems in the sector can be addressed. The white paper sets out to:

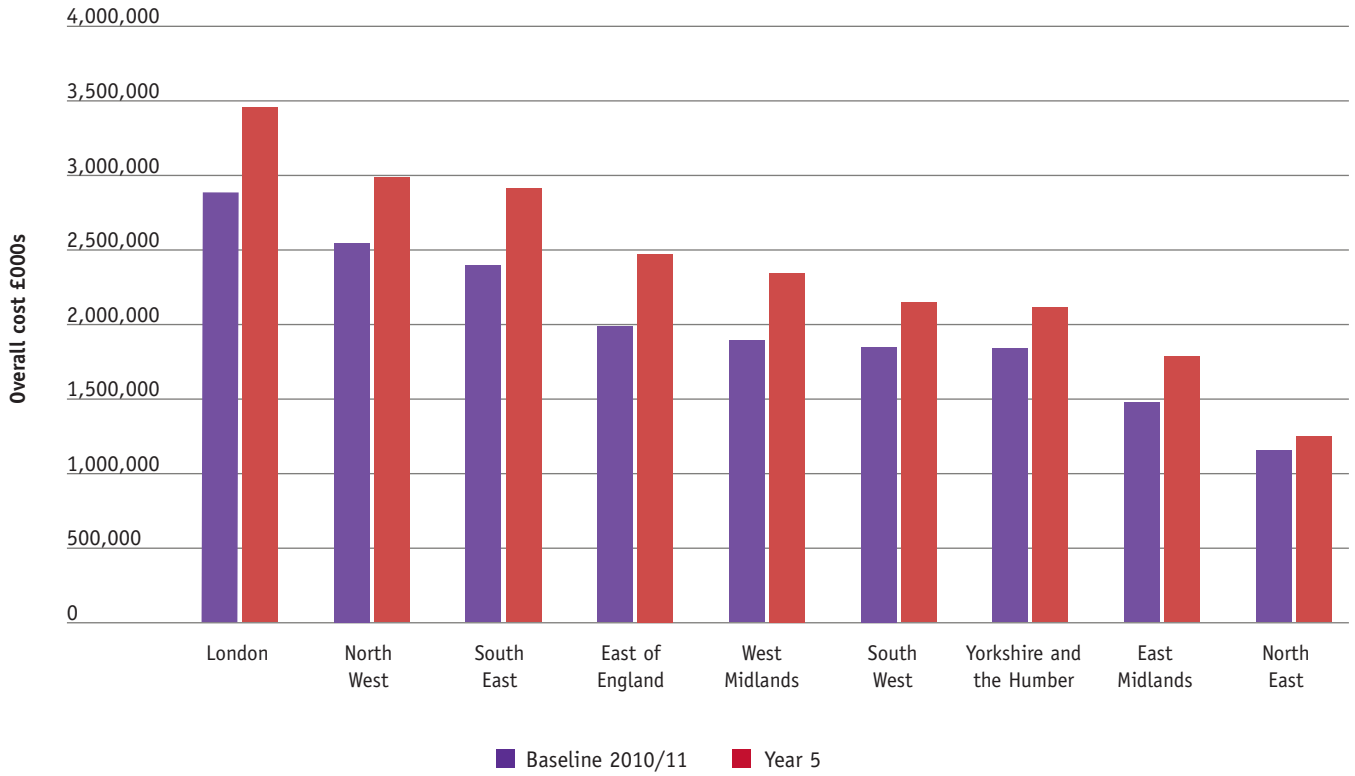
- Focus on people's wellbeing and support them to stay independent for as long as possible.
- Have greater national consistency in accessing care and support.
- Provide better information to help people make choices about their care.
- Give people more control over their care.
- Improve support for carers.
- Improve the quality of care and support.
- Improve integration of compensation to pay for care.

Some of the proposals for reform are expected to be implemented as soon as April 2015.

While government continues to consider options for the future funding of adult social care local authorities will have to continue to work with diminishing resources and increased pressures on the sector. To do this, local authorities will need to explore a variety of options and ways of working that will help them to maximise the funding they have available.

The following section explores how local authorities could respond to the growing demand to enable them to be able to meet their statutory responsibilities in adult social care without compromising the quality or quantity of care that is available.

Figure 6: **Impact of the Dilnot Commission by region**



↘04 going forward: responding to increased financial pressure in adult social care

Potential options for local government

Following London Councils' analysis of the impact of the Dilnot Commission's recommendations on local authorities in London, London Councils supported by Ernst & Young, explored the challenges facing the adult social care sector across the region and the opportunities available to meet those challenges.

From the workshops, surveys and interviews that were carried out as part of this project it became evident that, although local authorities were already responding to the increasing financial pressures and diminishing resources that they face in a number of ways, opportunities still exist to explore additional potential options that could increase local authorities savings in adult social care.

This report puts forward four key potential options that could result in substantial savings for local authority adult social care departments. The four options are:

- Health and social care integration – approaching care and health in a holistic manner requiring both health and local authorities to change the way they work to enable them to better align health and care.
- Implementation of alternative delivery models – local authorities moving towards delivering adult social care using different methods for example by using Local Authority Trading Companies (LATC)
- Category management - moving towards a more systematic and disciplined approach to procurement of services or goods.
- Public health – using the new powers of public health to improve the health of communities and prevent or delay the need for both care services and health services.

For each of these options, this report provides:

- A summary of the option outlining the potential benefits
- Case studies of where savings are being achieved from councils that are already implementing that particular option.
- Identification of potential barriers that could be faced by any local authorities aiming to implement that option.
- Financial modelling which illustrates the potential benefits that could be achieved by implementing the option.
- Lessons learnt so far from the adoption of such options.

It is important to note that the potential savings illustrated in the this report are only indicative projections which will vary from one adult social care department to another based on factors such as local decisions taken, local circumstances and political will, demography etc.

OPTION ONE: health and social care integration

As highlighted by the Dilnot report, it is critical to look at care and support for people from a holistic perspective, driving towards a 'more significant improvement in the provision of information and advice, and more joined-up working across the whole care and support system'. The current system is complex, difficult to understand and often delivers inconsistent services.

Integration offers the opportunity to improve patient/service user experience by designing a system that is easy to understand, provides consistency of intervention and more preventative, community-based and personalised services underpinned by a whole system approach to quality.

Lower costs can also be achieved for treating patients and service users, as preventative and community based provision tends to have lower overheads and results in keeping people at home for longer reducing the use of acute services. Organisational improvements are also possible, by developing a single view of the patient and service user that enables the removal of duplication, improved productivity and better targeting of resources.

A recent report by the King's Fund on emergency bed use for over 65's highlights the potential for delivering benefits. It examines the health and social care system, looking at the supply-side (hospital bed and community services) and demand side (patient based) factors that contribute to the variation in use of hospital beds by patients over 65 admitted as an emergency. The report highlights the potential reductions in bed requirements (potentially 5,700) if all Primary Care Trusts (PCTs) achieved the rate of admission and average length of stay of those with the lowest use. It also identifies those areas which have well-developed, integrated services for older people have lower rates of bed use.

Integrating health and adult social care – a borough perspective

The discussion at the workshop with Directors of Adult Social Services and the supporting survey with London councils highlighted that the majority of them had already begun the journey of integration, delivering integrated commissioning and provision for specific client groups, for example mental health, learning disabilities and physical disabilities.

Common areas of integration existed in terms of joint posts, jointly commissioned contracts with third party providers, shared placement costs and pooled budgets. There was general agreement across the councils that there is significant opportunity to more fully integrate commissioning and provision across client groups and bring together priorities across health and social care, if the aforementioned barriers were overcome.

As an example, Brent Council is considering further options for integration from structural integration of the commissioning functions to integrated re-commissioning of services for specific client groups e.g.re-commissioning of intermediate care services focused on avoiding hospital admissions. This latter opportunity explores benefits of re-commissioning services within scope of the emergency admissions sub-system, with a focus on deploying community based reablement and rehabilitative services along preventative lines, reducing the impact on hospital admissions and residential placements. Depending on the degree of integration adopted, financial benefits of up to £6.1m can be expected.

Integration is also beginning to take place across geographical boundaries. Under the Community Budgets programme, the Tri-borough councils (Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and Westminster City Council) have developed a business case to take a risk based approach to care and support for the most vulnerable in their own homes and communities, providing services that are seamless in their delivery in order to avoid hospital and care home admissions. Savings are expected to be approximately £50[14] million per year enabled by funding costs of £28 million. This is primarily driven by a reduction in acute hospital activity through investment in community and social care services. If outcomes are met commissioner and provider networks could share net savings estimated at £38 million.

Under a similar programme, Greater Manchester has also developed a model for integrated care for older people with long-term conditions with the expectation of similar benefits by moving resources and costs from hospital to community settings, diverting some resources and costs from health to social care services where appropriate; and integrating health and social care teams to reduce duplication and costs.

14 This is based on the triborough business case as at summer 2012

Barriers to integration of health and adult social care

The practical implications of realising these benefits are burdened with challenges. At the workshop with Directors of Adult Social Services, it was evident that barriers to integration sit across all aspects of the organisations involved, from the overarching structures, how they operate, to the culture of the staff and clinicians on the frontline. The status of acute systems across London is an added challenge with organisations trying to balance their budgets, improve the quality of services and integrate with social care.

Structurally, adult social care operates in an environment that is strongly influenced and governed by local politicians accountable to local residents and voters. Politicians have varying electoral mandates to take bold and radical steps, with some more risk-averse than others. Health services do not have the same governance requirements. NHS organisations are accountable for national targets and a regional strategy as well as the care of local citizens. Inspection regimes also differ significantly.

GPs are now a key player in integrating health and adult social care particularly with the emerging role of Clinical Commissioning Groups. GPs may not always have a comprehensive understanding and knowledge of the community based services and social care services available for users.

At an operational level, adult social care is rationed and delivered to those most in need of services and access to services is controlled through the application of eligibility criteria. There is also an expectation and requirement that users will contribute financially to their care if appropriate, whereas Health services in the main are free at the point of contact and assessment relates only to clinical need through diagnosis and not to eligibility.

Workforce development is also approached very differently by the two organisations and can be a barrier to integration.

Information sharing about patients and service users is also a barrier due to data protection regulations.

These differences permeate the organisation all the way through to the culture of those on the frontline. Anecdotal evidence suggests that there may be misunderstandings with regard to which services are delivered by NHS organisations and those services delivered by adult services. Examples include, in some cases, a belief that the adult social care reablement service can provide 24 hour care and overnight support and that health staff are able to provide quicker and free access to Telecare equipment. Understanding these barriers upfront, their severity and developing strategies for overcoming them is essential to successful integration.

Savings projections

While local authorities across the country and in London have been pursuing integration opportunities with their health partners for some time, there is a limited evidence base to draw from when considering the potential savings across the region.

A recent review[15] of integrated care pilots puts this largely down to a few key reasons including the lack of a robust methodology across the various pilot sites to measure savings. Identifying savings is further complicated by the changing nature of national policies, processes and legislations as well as unrelated organisational changes taking place in both health and social care settings.

Furthermore, the positive impact of integration can emerge in various ways along the service user/patient pathway which requires very close monitoring of activity to ensure the full scale of the benefits are included.

To enable us to carry out the financial modelling to estimate the savings that could be achieved by councils implementing more integrated working between health and social care we used the case study of the Tri-borough (Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and Westminster City Council) previously mentioned.

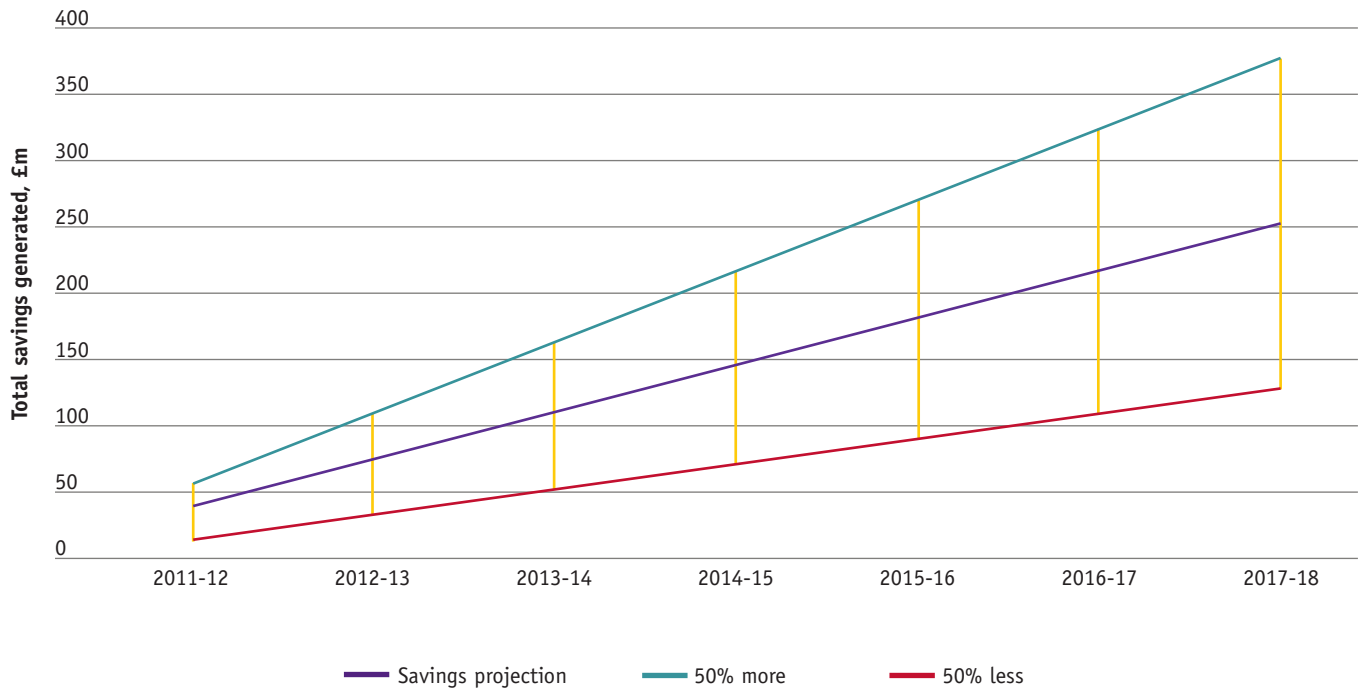
15 Department of Health (2012) National Evaluation of Department of Health's integrated care pilots. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133124

Our financial modelling looked at the potential savings that could be achieved if all the councils in London had a similar experience to that of the Tri-boroughs. The total benefits of integration from this experience are estimated to be approximately £50 million per annum. On the basis that savings are shared evenly[16] across the local authorities and the NHS and evenly profiled across a seven year period, it is forecast that these arrangements could deliver savings of almost 1.3 per cent[17] per annum on current gross expenditure.

As it is unlikely that all of London's boroughs would achieve the same levels of savings, figure 7 below illustrates the possible range of savings that could be achieved; if boroughs achieved similar savings then by 2017/18 London would have saved at least £248 million just from increased integration between health and adult social care. It shows that if the majority of councils achieved 50 per cent more than our case study then savings could be as high as £375 million, while if councils achieved less than 50 per cent of what the Tri-borough is managing to save then projected saving by 2017/18 would be £125 million.

It is important to note that the illustrated range in figure 7 is a sensitivity analysis to enable a broad range of potential outcomes to be illustrated. Actual figures would be subject to local decisions, local circumstances and political will.

Figure 7: **Potential savings from health and social care integration**



16 In the absence of detailed partner allocations of funding, it is assumed that savings would be shared evenly between the NHS and the participating authorities. In other such arrangements, it is thought likely that individual partner allocations will vary according to local circumstance and subject to negotiation.

17 This is based on the Tri-borough business case as at summer 2012.

Lessons learnt

Integration is about taking a systemic perspective on health and social care, bringing together disparate packages of care (clinical and social) and identifying key areas of interdependence between service provision. Services designed from this perspective secure improved individual and community outcomes including the financial sustainability of services. Integration can be achieved by looking at the needs of the patient/service user as a whole and analysing these alongside the 'macro' pressures. From these two elements it is possible to design an integrated care pathway based on a preventative, community based model of care that is financially sustainable.

Critically, benefits are also systemic which means the health sector and councils need to invest and save together based on a shared view of costs. The biggest financial benefits will ultimately be delivered to acute commissioning from reduced activity but the cost of re-provision falls on the councils and Clinical Commissioning Groups. The limited evidence available to prove that integrated multi-agency care and community care pathways actually saves money and the lack of an 'invest to save' culture across management in both organisations further hinders the commitment to integration

While there are many examples of integration between health and social care that have led to improved care pathways and better patient and service user experience and efficiencies across the economy, there are equally criticisms and lessons to be learnt from how integration has been approached. Starting from the initial conversations through to benefits realisation below are a few examples of lessons learnt that need to be considered when taking the steps towards health and social care integration.

- There is often insufficient time and attention given to developing a clear understanding of the baseline of services being provided and commissioned across the health and social care economy can lead to misunderstanding of the interdependencies during option development and subsequent appraisal.
- Research and evidence is ideal to base change on, but is patchy across health and social care, many stakeholders have seen the absence of data as a blocker and have not drawn on the expertise within the practitioner group which can support building a data set re-enforced by assumptions based on real world experience in the economy in question. Taking this approach can also help to improve the level of bottom up buy-in essential for changing the culture of silo working.
- There are a range of options for approaches that can be considered for integration starting with a pilot of niche integration to create proof of concept and buy in across the full range of stakeholders leading to evolutionary integration to the creation of new service delivery vehicles. Each is equally relevant; however, organisations need to decide which approach is most appropriate for them given their particular desires and need to realise benefits.
- Failure to recognise the appropriate level of detail required for aligning commissioning vision and intentions i.e. focusing on the development of a new delivery vehicle prior to agreeing commissioning intentions or identifying synergy opportunities in the existing pathway. It is all right not to have all the answers at the start, integration like all change is phased with increasing levels of details and confidence as the project progresses.
- Lack of awareness of when to engage with provider stakeholders and how to use these relationships to improve commercial awareness thereby improving the development of an integrated service offering as well as allowing providers the opportunity to consider alignment of their own operating models.

It is critical to have upfront negotiations with health partners outlining how financial benefits will be apportioned.

Further examples of common mistakes and lessons learnt can be found in the *National Evaluation of Department of Health's Integrated Care Pilot.*[18]

18 Department of Health (2012) National Evaluation of Department of Health's integrated care pilots. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133124

OPTION TWO: Alternative delivery models

While integration may be one solution, other options exist which local authorities can implement to help them address the challenges that they are faced with.

Following waves of outsourcing and new commissioning approaches, elements of adult social care are now delivered by the third and private sectors. However, many local authorities have retained some level of directly provided adult social care services. These often include specialist day and residential care and re-enablement home care. Many authorities are reviewing these to determine whether services can be provided more efficiently outside of the local authority.

The use of new service delivery models can allow local authorities to benefit from reduced costs while allowing a certain level of control over the provision of services and retention of highly qualified and skilled members of the workforce. New service delivery models would not conflict with the wider move towards greater personalisation and an increase in the number of service users with personal budgets as new service delivery models can also be used to manage the personalisation agenda reducing the local authority's costs.

There are a range of potential benefits associated with switching to new service delivery models. However, benefits are linked to the option pursued and are listed below according to the options:

- Local Authority Trading Company (LATC): Maintains a link to local authority influence and brand, reduced staffing and corporate costs, ability to trade with all sectors of the market creating potential to generate future capital receipts, retains capability and capacity to provide a strategic response to emerging trends and challenges.
- Outsourcing: Commercially independent, service delivery risk transferred to a third party, private capital and enterprise can improve delivery, low costs of implementation as the cost of transfer can be borne by provider, when underpinned by robust and effect contract management can achieve sustainable quality and performance improvements.
- Social enterprise or public service mutual: Accessibility of alternative funding streams, flexibility to meet the needs of clients as front line staff have more influence on the service delivered, profits can be reinvested, lower capital cost, risk transfer to a third party, commercial independence and involves stakeholders and service users in development.
- Shared services and joint ventures: Continued access to council staff and expertise, certainty about service costs, stakeholder commitment leads to stronger future relationships, experience and expertise in the marketplace shared among partners, standardisation of processes enabling more effective use of resources.

Alternative delivery models – a borough perspective

Several authorities have responded to this challenge of diminishing resources by using the power to trade to establish trading companies that provide social care services. Where Local Authority Trading Companies have been successfully established they have resulted in tangible improvements in customer service while simultaneously enabling significant efficiency savings through reduced bureaucracy and increased flexibility to cope with the differentiated needs of service users.

This combination of public service ethos and private sector discipline has enabled trading companies such as Essex Cares Ltd, Croydon Care Solutions and Optalis Ltd (Wokingham Borough Council's trading company) to deliver significant efficiency savings and improved value for money. Essex Cares has improved performance, reduced staff sickness levels from 16 per cent to 4 per cent and delivered a trading surplus of £3.5 million in 2010/11 and savings of £11 million over 3 years.

Croydon Care Solutions has delivered approximately £200,000 of savings in 2011/12 and at the same time service users have experienced improved choice and quality of care. Optalis Ltd have contracted financial benefits of £3.025 million over 5 years.

Trading companies also have the potential to generate additional income through trading, for example with private individuals, private sector providers and other public bodies, for example Essex Cares now provides reablement services on behalf of another local authority.

Social Enterprises are also gathering a significant following. Bath and North East Somerset set up a social enterprise in 2011 and Kingston is in the process of transferring local authority in-house residential care and day services to the social enterprise which runs NHS community services.

Alternative delivery models also provide an opportunity for integrated services with Health. For example, Torbay Primary Care Trust was formed in December 2005 when the community health services and adult social care services (previously provided by Torbay Council) were integrated.

The benefits of this have included:

- A single strategic approach and public sector ethos with service users at the heart;
- Simplified management and decision making;
- Improved communication and easy access to better information;
- Reduced bureaucracy and duplication of effort;
- Increased efficiency and effectiveness and;
- Improved coordination and access to services.
- Taking market share back from the private sector in a way which creates and supports living wage jobs rather than minimum wage jobs but has a lower cost-base than a London borough.

More recently, Richmond has been given approval to undertake a feasibility study to explore how greater integration between health and social care services can be achieved, enabling improved community health and social care arrangement for older people and adults with disabilities. They are assessing whether the best way to deliver greater integration is to set up an integrated care organisation jointly with Hounslow Council and the Hounslow and Richmond Community NHS Trust.

Barriers to implementing alternative delivery models

There are significant challenges in implementing these new delivery models and the process of set-up can be lengthy, complex and expensive. The relatively higher costs of TUPE can make achieving market competitiveness more challenging.

There are also a number of inherent risks in these models, including the inability for new models to deliver services due to market uncertainty, potential conflict between the new entity and the local authority.

There are also VAT implications to be considered in regards to new service delivery models, as new companies will need to comply with all the regulatory requirements of the Companies Act 1985 and additionally with the regulatory regime for local authority companies under the Local Government and Housing Act 1989. Some recently established LATC vehicles have adopted company structures and procedures that have minimised the negative impact of VAT and Corporation Tax; eliminating the previous financial disadvantages of adopting an alternative service delivery model and maximising the ability to deliver cashable savings and a viable future for services. This has been done via individual negotiations with HMRC around structure and arrangements that ensure the Tax treatment of transferring care services to an LATC is on the whole identical to that currently enjoyed by Local Authorities However, HMRC have not issued a general clearance of this structure as they consider specific fact patterns and it would be necessary to approach HMRC for clearance on each individual case.

Critical to implementing an alternative delivery model is gaining political buy-in and commitment to the idea. The benefits that can be achieved need to be articulated in a robust and comprehensive business case that balances the reduction in control and various risks with the positive impact on outcomes for service users and the organisation.

In developing the business case for an alternative delivery model, 'scale' is critical to its success, as it is volume that will provide the benefits and sustainability in the longer-term.

Savings projections

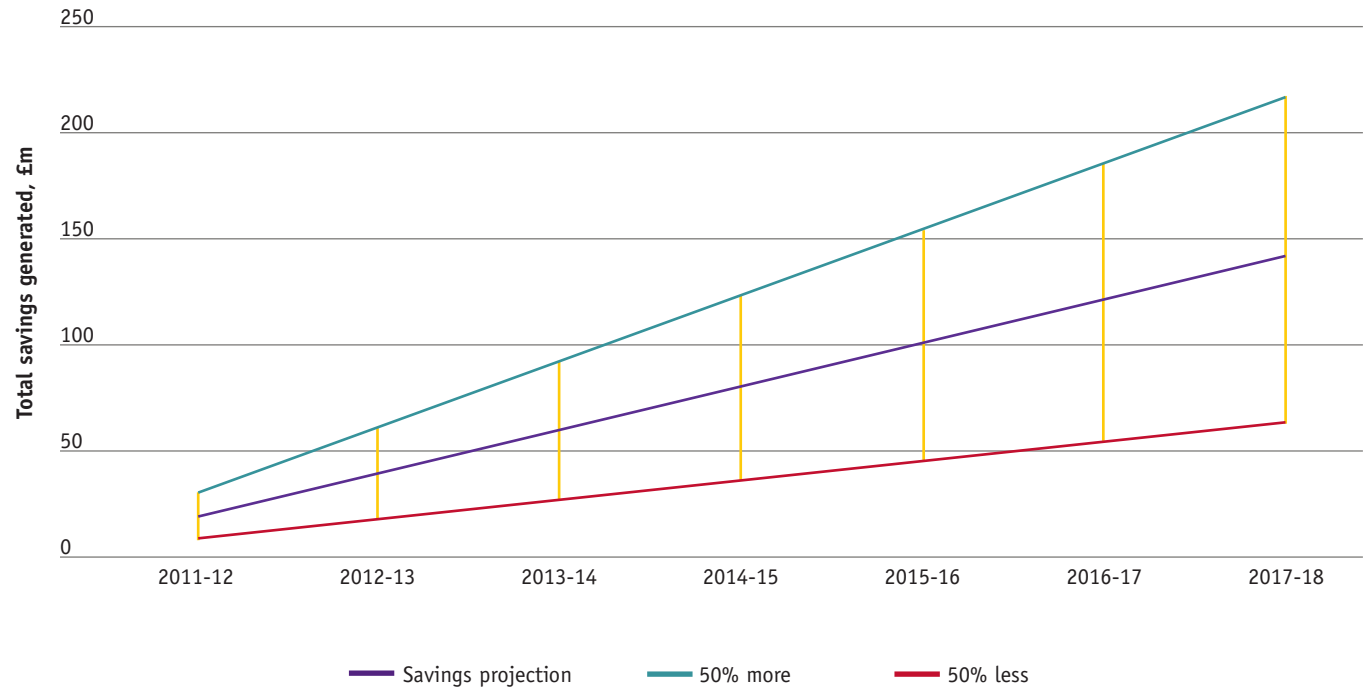
The potential savings to be achieved from new service delivery model are heavily dependent on the kind of system being considered as well as the maturity of the new model. Due to TUPE transfer restrictions and the nature of transitioning to a new delivery vehicle the savings will be achieved over a three year period.

Essex has adopted a successful approach to service configuration, delivering a savings programme of £11 million over 3 years on a gross cost of £498 million. Using their approach as a benchmark[19] and on the basis that such an approach could be transferable, delivering a reduction in current expenditure of approximately 0.78 per cent per annum, our research found that were all councils in London to implement Essex's approach and achieve similar savings then by 2017/18 London as a region would have achieved just under £144 million in savings see figure 8 below.

It is important to note that the illustrated range in figure 8 below is a sensitivity analysis to enable a broad range of potential outcomes to be illustrated. Actual figures would be subject to local decisions, local circumstances and political will.

Figure 8 shows that if all councils were to achieve 50 per cent less than the savings currently being achieved by Essex County Council then by 2017/18 London would achieve savings of £70 million as a result of setting up new delivery models. This could increase to savings of £220 million if councils were to achieve 50 per cent more savings than Essex County.

Figure 8: **Potential savings from implementing new service delivery models**



19 No regional wage differences have been factored in to the calculation of the savings projections.

Lessons learnt

There are a number of alternative key lines of enquiry that can be explored when learning the lessons from the implementation of new delivery models. One example is that of governance, which includes the vision, management structure and alignment to the parent organisations strategy, market analysis of national and local trends, the assessment of growth potential and prioritisation of opportunities and the supporting financial analysis to assess the revenue growth plans and efficiencies. Some of the lessons learnt include:

- There is often a lack of attention given to the alignment of the new service delivery options with wider corporate or council wide transformation initiatives, leading to a disjointed approach and failure to identify interdependencies and opportunities for transformation or alignment
- Taking a project management approach to the transformation can help to ensure successful delivery of a new service model. This approach supports:
    - Clear project governance via a formal project board to hold the project to account.
    - A project manager with dedicated time to ensure milestones are met and deliverables on track.
    - A gateway approach to decision making and that keeps the transformation manageable and allows for a more tightly managed project
    - Consideration on how to manage potential 'blockers' to the project, either individuals or ingrained corporate behaviour that acts to slow the programme down.
- Understanding the business plan in the local context and competitor landscape through an in depth analysis of the local market and more in depth market research on potential for services being tendered by other councils is also very important.
- Assessment of organisational and staff capability should be tested and applied at lower levels in the organisation to determine if a change in skills or resource may be required
- Alignment to the councils' priorities and infrastructure is vital as there is a need to align the strategic ambition of the organisation with the council structure through further discussion and iteration of a plan, clearly demonstrating a link to a council's political priorities and consideration of the ability to achieve back office efficiencies co-owned by council
- Financial case for growth projections, improved performance and the achievement of efficiencies is often an area where there is an over statement of proportionately low levels of investment to achieve high levels of growth and in instances where the financial case is based on high growth at a low margin while delivering efficiencies but there is an inherent risk in chasing growth not profitability
- Communication and engagement with all stakeholders is a key to ensuring successful implementation of any change. It is imperative that a communication and engagement plan be established from the start of the programme.

OPTION THREE: Category management (procurement arrangements)

Category management refers to the systematic and disciplined approach to procuring services and/or goods of a similar nature – known as categories. Such an approach could be carried out by an individual local authority or a group of authorities. Within local government, these categories could include areas such as adult social care provision, construction, ICT and agency staff. Through the development of tailored procurement approaches to the identified category, it may be possible to deliver cashable savings through the development of a greater understanding and more effective interaction with market providers.

A systematic and disciplined approach to procuring adult social care provision also presents an opportunity to ensure resources are used more effectively while maintaining the highest quality of service. Work is currently underway to develop category management strategies within London, under the guidance of the London Procurement Strategy Board. There are already a number of London procurement groups e.g. the West London Alliance, which support the achievement of efficiencies from collaborative procurement. Recent moves towards more personalisation are likely to impact large scale procurement and future potential savings.

Category management – a borough perspective

At an individual council level, several councils are already adopting category management within directorates or at council level. For example Richmond has implemented a centralised procurement function underpinned by category management, to support the council's journey towards becoming a commissioning council. There are three procurement hubs, one of which is focussed on people e.g. residential care, non-residential care and adult community services. This new approach is expected to deliver savings in the region of £7 million to £16 million per annum from across the categories. Where other council's have begun to move in the direction of category management but have not embedded it fully e.g. Bromley with a centralised Education and Care Commissioning Department, this has been down to the cost of resources to offer the degree of specialism required.

In some instances, authorities are implementing a *supplier relationship management* approach, where providers work with a lead commissioner from the council, or health if the commissioning arrangements are integrated, managing the relationship and understanding the providers' service and business model. This approach can be supported by a number of innovative procurement routes for example on-line procurement portal which enables providers to 'bid' for individual packages of care as they are required or quality frameworks where providers are procured onto a framework agreement with a pre-agreed fee structure and set of quality (or other) factors.

To mitigate financial risk, these procurement routes should be supported by a clear understanding by commissioners of the usual local cost of care. In addition to mitigating the risk of Judicial Review through avoiding opaque fee setting processes that have not considered provider costs, commissioners would also need to have access to good quality market intelligence to inform decision making about particular placements, both in terms of value for money for the council and business sustainability for the provider. Having a transparent negotiation process can also help to detoxify what are sometimes complex supplier relationships.

Through engaging with the provider base, a quality framework agreement can be developed that drives an agreed cost of care linked to agreed quality standards. This approach has been successfully applied with care home providers and commissioners. For example, the Royal Borough of Greenwich has moved from a mix of block contracts and spot to spot purchase arrangements for residential care and new Domiciliary Care Framework agreement for approved providers. Savings of £500,000 per annum are anticipated from this move. Implementing this approach on a single authority basis, close cooperation is required between social care, finance, procurement and the provider base.

Barriers to Category Management

A key benefit from category management can only be derived once there is an optimal number of councils which would require cross borough or sub-regional working. For a successful procurement to be taken

forward, it would need participation by as wide a grouping of boroughs as possible to exploit maximum purchasing power while also avoiding unnecessary duplication of effort. For example, a Tri-borough framework for category management has recently been set-up across Hammersmith & Fulham, the Royal Borough of Kensington and Chelsea and Westminster City Council for health and social care contracts with the current three year plan projecting savings of £2 million.

However, in some cases cross-borough/sub-regional working could be a barrier as where boroughs wish to collaborate on a cross borough or sub-regional basis, high-level officer buy-in and possibly political buy-in is necessary to ensure a structured and cohesive approach to category management. This can often be challenging due to political differences and conflicting local priorities between councils.

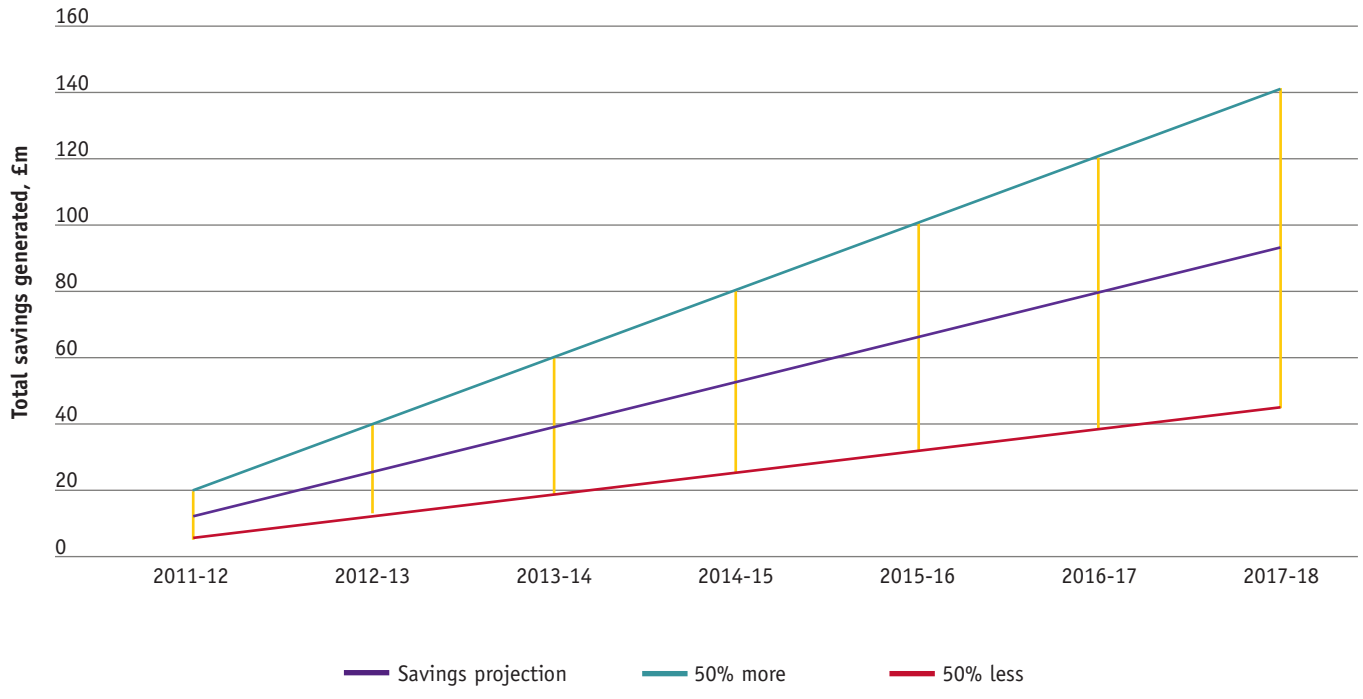
Savings projections

Category management is already resulting in considerable savings in those boroughs that are implementing it. For the purpose of this research we used figures from the Royal Borough of Greenwich as basis for calculating projected savings that would result from all councils in London implementing category management.

The graph below illustrates that if all local authorities were to implement category management as a standard way of procurement and then achieve savings similar to those of Greenwich then potential savings that could be attained by London boroughs by 2017/18 would be £94 million. However, if boroughs were able to get 50 per cent more savings than Greenwich is currently achieving then potential savings for London could be as high as £140 million whereas if boroughs get 50 per cent less than Greenwich is currently achieving then savings by 2017/18 would be approximately £45 million.

It is important to note that the illustrated range in figure 9 is a sensitivity analysis to enable a broad range of potential outcomes to be illustrated. Actual figures would be subject to local decisions, local circumstances and political will.

Figure 9: **Potential savings projections from implementing category management**



Lessons learnt

Several lessons can be learnt from the experiences of those boroughs that are already implementing category management. Some of these lessons are set out below:

- Legal challenge can be initiated where the fee setting has not paid due regard to the local cost of providing care. Through a process of engagement and negotiation, underpinned by financial and technical expertise, local authorities can work with providers to demonstrate a robust evidence base for decision making.
- This same approach can also help to further encourage the provider base to move away from antiquated models of care that fail to support current care needs of the population (e.g. dementia/ specialist palliative care) and don't reflect changes to the national and local agenda that is moving increasingly towards personalisation and user choice.
- Financial modelling and fee development in isolation of negotiation can cause significant damage to the relationship with providers. Engaging them in discussions, negotiating the financial rules to be used and communicating your commissioning intentions re-open this relationship to achieve a more successful, collaborative solution. Through listening to concerns, dispelling myths around treatment of financial data and demonstrating a clear commitment to a resolution that is fair for the user, the council and the providers helps to create a more sustainable and positive relationship with the provider base.
- There can often be a gap between the strategic commissioning and category management leading to a lack of understanding in how changes to commissioning intentions can impact on the delivery requirements of a particular category. This link is important to ensure that commissioning and decommissioning intentions are communicated and realised through implementation e.g. a reduction in the number of residential care bed weeks over time as a result of an increase in reablement and other preventative services being commissioned that reduce the demand for residential placements.

OPTION FOUR: The use of public health funding for prevention and the wider preventative agenda

From April 2013, public health responsibilities will transfer from primary care trusts to local authorities. Local authorities will receive a ring-fenced public health grant and will have a duty to use this grant to promote the health of their population and will also take on key functions to ensure that robust plans are in place to protect the health of the local population. This shift in responsibility will enable local authorities to take the lead for improving health and coordinating local efforts to protect the public's health and wellbeing, and ensuring health services effectively promote population health.

The government has identified four core reasons for transferring public health to local authorities, namely:

- Population focus - local authorities are best placed to take a whole population perspective in addressing local health and wellbeing needs.
- Local authorities' ability to shape services to meet local needs.
- Local authorities' ability to influence wider social determinants of health.
- The wealth of knowledge and experience of tackling health inequalities that exists in local authorities.

Although the government has also identified areas that the public health funding should be used for, part of this funding can also be focussed on promoting behavioural change and healthy choices supporting people to live longer healthier lives and reducing premature death and illnesses. This gives local authorities the opportunity to begin to address long-term issues so as to reduce the pressure on the adult social care system in the long-term. For example, intensive investment in obesity control such as nutrition and exercise will in the long-term result in people living healthier lives for longer with a reduction in chronic diseases such as Type 2 diabetes and heart disease. Public health funding can also be used in the early diagnosis of illnesses by increasing health screenings so that people are given help before their illnesses progress further.

Other areas that public health funding can be used for that would help to alleviate demand for adult social care are:

- Public mental health services
- Behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Public health aspects of local initiatives to tackle social exclusion.

The transfer of public health is in its early stages and the indications from the Department of Health are that this is being well-handled from a London borough perspective. There needs to be early engagement between key partners such as the NHS, Clinical Commissioning Groups and Health and Wellbeing Boards if the benefits of this investment are to be maximised.

It is important that local authorities are adequately funded to deliver their new responsibilities for public health. It will be important that there is a quick change from basing the allocations on historical spend to actual need and for the department of health to continue meeting this need for all boroughs.

The engagement of Clinical Commissioning Groups and Health and Wellbeing Boards is critical as both have a role in committing to the health and wellbeing of their communities and therefore play a key role in the prevention agenda. There is also an ongoing role for the private sector to play in meeting their social responsibility to communities.

The use of Public Health funding for prevention and the wider preventative agenda – a borough perspective

There are some excellent examples across England of services that identify need at an early stage and provide support that prevents or delays the need for higher intensity or institutional care. Examples include the Partnership for Older People Projects (POPP), funded by the Department of Health, to develop services for older people, aimed at promoting their health, well-being and independence.

The evaluation of this project found that a wide range of projects (with 29 councils involved) resulted in improved quality of life for participants and considerable savings, as well as better local working relationships. Another example is the Gloucestershire County Council 'Village Agents' where local people are recruited, trained and paid to work approximately 10 hours a week within clusters of communities. They target people aged 50 and over with information, carry out practical checks, identify unmet need and support people to make choices.

Opportunities also exist by working more closely with the voluntary sector. Merton is changing their programme with the voluntary sector under the key principles set in the compact, an agreement between the government and the voluntary and community sector, which sets out key principles and establishes a way of working that improves their relationship for mutual advantage. The council has ring-fenced prevention money for the future in return for a commitment to move to a more outcomes based approach. They have also disinvested in some less effective programmes, with the support of the voluntary sector collectively. The council recognises that cause and effect are difficult to prove but expects that the impact of the programme will be to limit future demand and reduce the requirement for adult social care to receive demographics from the council.

There is scope to exploit these benefits further but this requires additional investment. Within the confines of councils this opportunity is limited due to financial constraints. Working more closely with health can provide this investment. For example, Richmond is using section 256 funding jointly with its PCT to fund a number of preventative programmes including a joint community rehabilitation service, and the Falls and Bone Health service.

Time-banking is also becoming more and more common for communities supporting themselves. For example, Lambeth's credit-based time bank (Clapham Park time bank) is a great example of this in practice. Set up to promote residents' mental well-being, it allows citizens to earn credits for each hour spent helping other individuals in their local community, addressing gaps in the provision of statutory services

such as enhancing social network to address issues of isolation. There is no escaping the requirement of upfront investment in these initiatives not only from the councils but also from its partners and the communities they serve but the benefits are of a much more strategic nature, serving to create sustainable delivery models that will dampen future demand.

Fundamental to this agenda is increased community and partner engagement and involvement in order to explore how we can work together more co-operatively to address issues. Working more closely with the local community can enable the councils to draw on a wider pool of resources and explore new ways of doing things so that a real partnership with local communities can be developed. The approach of co-production has the potential to deliver responsive services that are more aligned to the needs of the community and deliver improved outcomes - a move away from a 'one size fits all' approach to one where customer insight guides service design and delivery and where a new relationship can develop between the council and its community.

This approach lends itself to the exploration and potential creation of community-led or owned organisations which can encourage communities to become more self sufficient changing the role of the council to that of a facilitator rather than a provider, shifting the responsibility and accountability to the community and reducing the pressure on council resource. Working more closely with Health will provide the opportunity to planning collectively to identify those, in need or at risk, agree on where to shift investment to earlier intervention and jointly measure success.

Savings projections

The public health and prevention agenda is a relatively new agenda for local authorities. It is difficult at this stage to make accurate projections based on borough experiences as there are no examples that could be used.

However, public health has been included in this section of the report because if boroughs were allocated the appropriate levels of funding then there is potential for public health to play an important role in achieving savings in adult social care.

Lessons learnt

As the transfer of public health funding to local government will not happen until April 2013 many of the examples that we have had to draw on are not fully realised or developed. From a general preventative services arena there are a few lessons to be learnt;

- In some instances, it is difficult to measure the effectiveness of preventative services given the complex nature of the health and social care economy and inability to identify an appropriate control group within the population.
- The piecemeal approach to commissioning small services can often lead to gaps or overlap in provision based on historical commissioning intentions.
- Lack of clarity around user base and inability to target most appropriate population thereby failing to manage demand on more costly service. Again this is compounded by the inability to track service users who are accessing services at a preventative level as case management systems are reserved for service users receiving social care intervention.
- Interventions applied along the pathway can result in reduced demand and subsequent costs in different parts of the system; therefore it is crucial for all services to contribute to the cost of early intervention.

What needs to happen to enable these potential solutions to be delivered and to maximise the borough role in reducing the funding gap?

Through exploring these different solutions with representatives from across the social care sector in London, supported by Ernst & Young's experience, it has become apparent that there is no 'one size fits all solution'. Councils are implementing a variety of solutions to address the growing demand and diminishing resources based on what works for them given their political standing and relationship with key partners and the community. This section has been divided in to two parts the first highlighting what local authorities need to do to enable these potential solutions to be implemented and the section identifies how the government can provide an enabling environment for local authorities to implement these options:

Local authority role

Councils can take steps to broaden the number of solutions available to them and increase the likelihood of their success by addressing the key barriers that we have described. These steps are all underpinned by increased engagement with key stakeholders so that a shared understanding of the problem exists and that there is a willingness to work together to co-design and deliver solutions. These stakeholders include health partners, other council directorates, Elected Members, other councils as well as the private sector.

Health partners need to be engaged at a local and regional level to develop a shared understanding of the health and social care economy and to work in collaboration to develop a body of evidence of impact that increased investment in preventative and community based services can have on the system, modelling the financial impact on the health and social care system as a whole. They need to be encouraged to take a longer-term view even if they may not necessarily benefit in the short-term as some benefits take longer to reach fruition. They also need to be encouraged to develop joint governance and ownership of information, where collective decision making holds all partners to account for outcomes and savings across the system.

Furthermore, local authorities need to have in place an intensive information dissemination service of community based services available. This should be targeted at GPs who should play a central role in sign posting people to services. GPs should be kept well informed with information on the services available locally and should have easy access to enable them to offer people a range of choices.

Collectively approaching themes such as early intervention and prevention as one council will also provide ways to help manage future demand. Greater engagement can also lead to improved buy in from the corporate centre to the potential options available to help fill the funding gap. Councils often develop solutions from within Directorates e.g. the Economic Development directorate focussing on early intervention initiatives for unemployed. Through information sharing and pooling of resource to develop more holistic initiatives, a greater impact can be achieved. This is particularly important when considering the development of new service delivery vehicles as the corporate centre will need to be engaged to view this as an opportunity for rationalising the back office functions as opposed to viewing it as a threat to their re-charge revenue generation.

Officers need to articulate the whole system impact of integration to elected members so that when it comes to tough decision-making, for example the closing of hospitals in a move to greater community based services, politicians are able to gain community support and allay fears and concern of reduction in service and quality.

Elected members also need to recognise the need to put political differences to one side and work more closely with neighbouring authorities. Conversations across council boundaries to examine potential efficiencies through economies of scale, for example through alternative models of delivery or improved category management, are needed. The development of LATCs in every London borough would diminish the ability to trade within the region. Therefore, it would be more beneficial for local authorities to come together and consider the impact across their local area beyond their boundaries. Elected members have a key role in using their sphere of influence to gain

commitment and buy-in to the options discussed in this paper from the full range of community partners including health.

Central government role

Government also needs to play its role in addressing the barriers to implementing these solutions. It needs to recognise the need for increased investment in prevention and the dividends it can pay in the longer term, before the problem gets too out of hand. It also needs to work with local government and the NHS to help align policies and reporting arrangements to enable integration to take place. It needs to develop and implement a common performance framework to ensure joint accountability for outcomes.

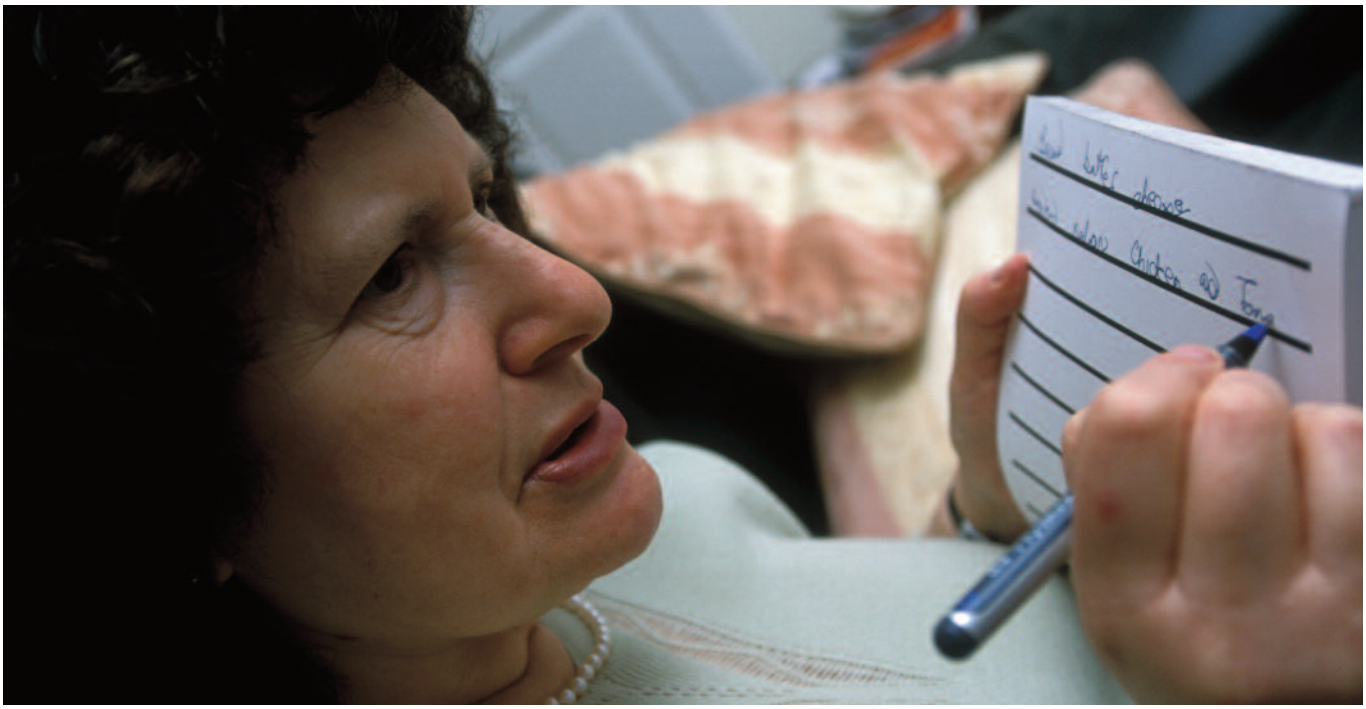
At a regulatory level, government needs to change care regulations and the Caldicott rules so that information can be shared more readily across health and social care organisations. From a payment perspective, government needs to change payment models in health to incentivise delivery models. For example, by moving away from a tariff-based system within Acute Trusts as this results in activity based payments, with little incentive to reduce that activity.

There is also the potential impact of business rate reforms on the ability of LATCs to generate local growth by trading with the private sector. The public/private divide has yet to be fully explored when considering how LATCs might be able to support the wider business community in terms of the provision of back office functions i.e. payroll and business administration support for small businesses. The provision of these services at affordable costs could allow new businesses to establish themselves and existing small businesses to focus on growth thereby leading to increased business rate collections by the local authorities.

However, in order for this to work, VAT and corporate tax implications need to be addressed in a way that encourages local authorities to be bold and innovative in their decisions about how to help make services sustainable in the longer term.

Government also needs to review the tariff system of Acute Trusts so that they can be incentivised to play a bigger role in community based services. For example there could be an award system put in place to reward acutes to invest in community based services.

The following section of the report explores what the funding gap is in adult social care and illustrates how the funding gap is a growing concern for councils.



↘05 understanding the funding gap in adult social care

This section of the report looks at the funding gap in two different ways:

- Funding gap based on projected expenditure.
- Funding gap based on the assumption that local authorities are able to make savings by implementing the options discussed in this report.

Understanding the funding gap using projected expenditure

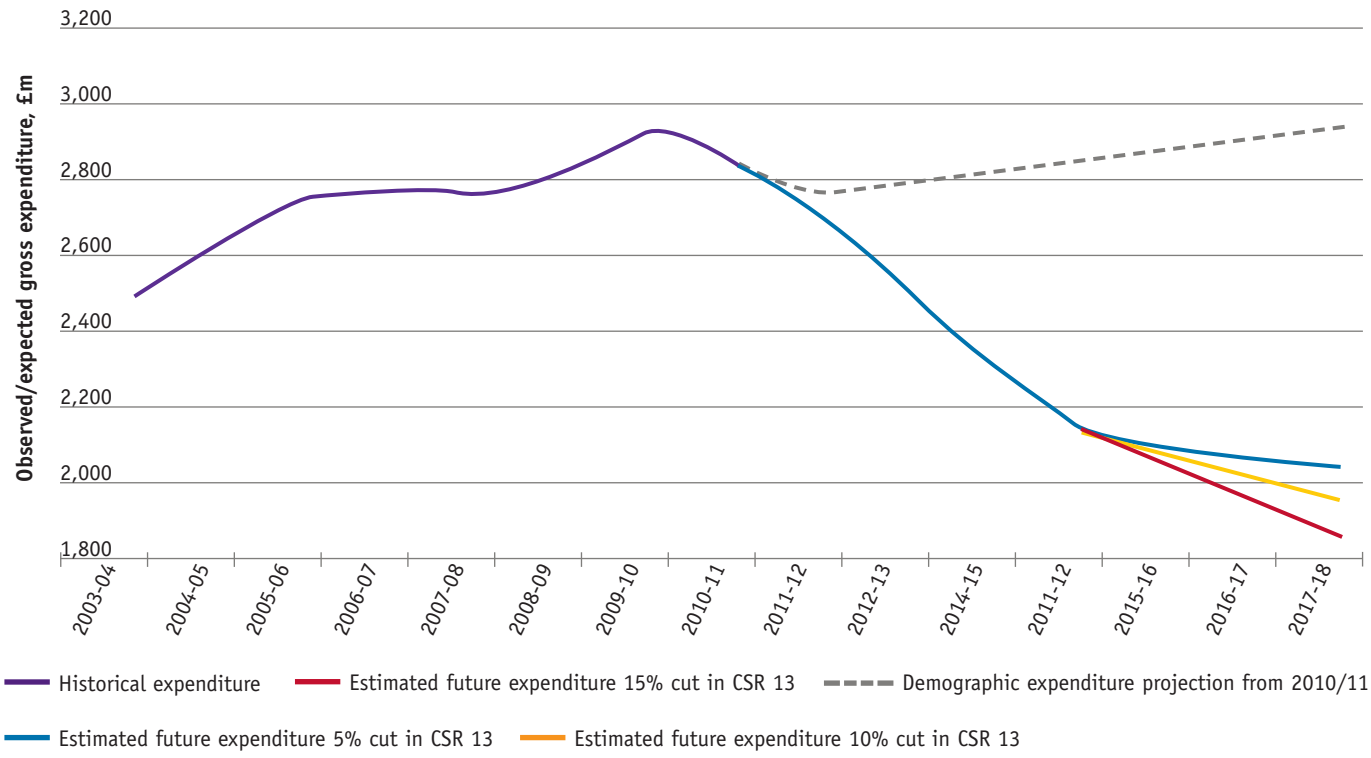
Local government has always argued that there is funding gap between the funding allocations from government with the actual need for adult social care based on the demographic data available. This section of the report sets out the current funding gap.

Using historical expenditure going back to 2003/04 and forecasting to 2017/18 the financial model developed by London Councils has enabled an exploration of what the potential savings boroughs are likely to make and an illustration of the potential funding gap likely to face the sector 2017/18.

Following the spending review in 2010 local authorities were faced with a 28 per cent cut to their overall budgets and local authority budgets are expected to be cut further in the next spending review. It is important to note that although adult social care funding is not ring-fenced, the majority of councils in London have taken the decision to protect their adult social care budgets and have not automatically put through 28 per cent cuts to their adult social care departments.

However, because local authorities are facing increasing financial pressures it will be difficult for local authorities to continue to protect adult social care budgets following the next spending review. Figure 10 over, illustrates what the potential funding gap in adult social care would be by 2017/18 if the next comprehensive spending review were to implement potential overall budgets cuts to councils of 5 per cent, 10 per cent or 15 per cent. With projected demographics pressures expected to continue to increase our projections are that expenditure on adult social care would drop from current levels of around £2.84 billion to a minimum of £1.83 billion by 2017/18 if all local authority adult social care budgets were to be cut by at least 15 per cent. This shows a difference between projected local authority expenditure and projected demographic expenditure, in other words, a funding gap of nearly £1.1 billion.

Figure 10: **Gross expenditure projections for adult social care**



While the projected expenditure set out in the graph above makes several assumptions regarding the possible impact of the next comprehensive spending review, one thing is definite: local government expenditure based on current expenditure levels will continue to diminish. Local authorities will have to continue to deliver and commission adult social care and support with diminishing resources, or see adult care squeeze out spending on all others services provided by councils.

Would there still be a funding gap if local authorities were to deliver all of the options discussed in chapter four?

Government is keen to see councils maximise the efficiency savings that they can get from the way they deliver adult social care services. Increasingly, local authorities have been faced with challenges to commission and deliver services in a climate where the resources available to them are reducing as part of the wider reduction in funding to local authorities filters through.

Local authorities have responded to the funding challenges by exploring various options to achieve the necessary savings, some of which have been discussed in this report. However, councils are at different levels in this process, while some local authorities have already begun implementing some of the options discussed in this report, and have been used as case studies others are still considering which options would suit their authority best.

Local authorities are at different levels in this process, while some local authorities have already begun implementing some of the options discussed in this report, and have been used as case studies others are still considering which options would suit their authority best.

This report has in particular explored the potential impact of local authorities implementing four possible options to achieve savings namely:

- Health & Social Care Integration.
- Alternative service delivery models.
- Category management.
- Public health (although no actual savings projections are proposed)

Figure 11: **Potential savings from implementing all four potential options**

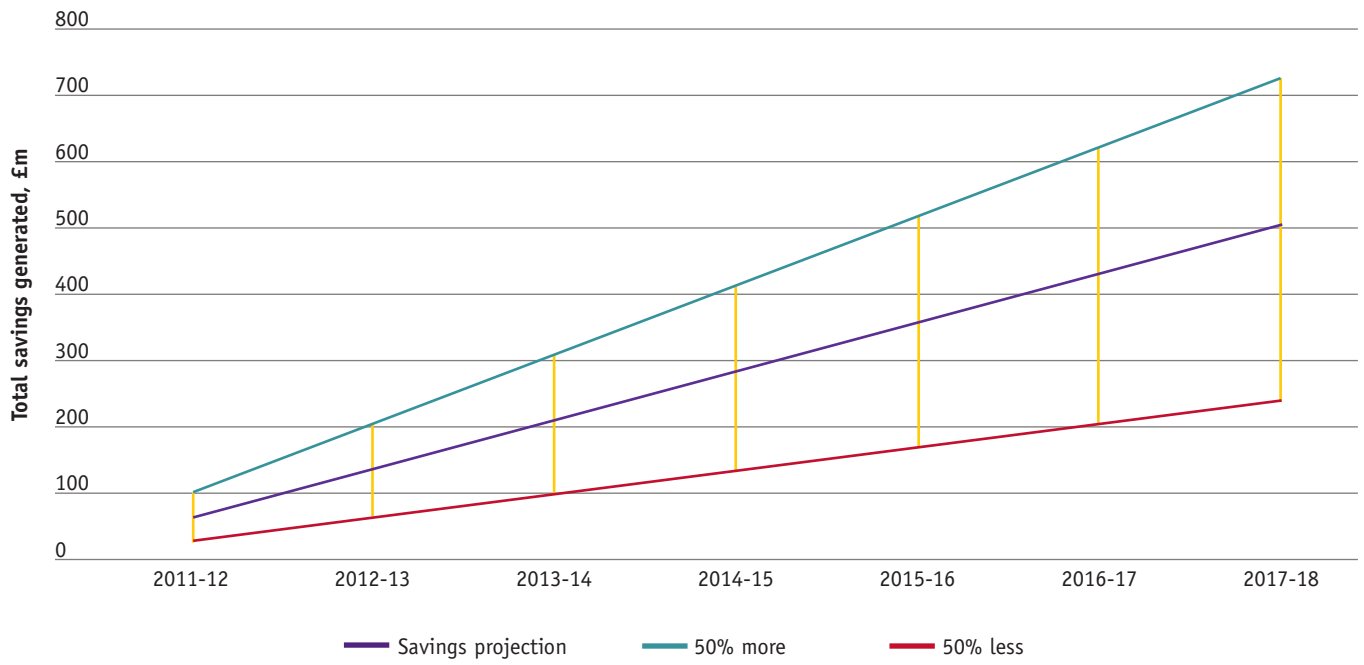


Figure 11 above looks at the potential savings that could be achieved by councils in London if all councils were to implement all the options discussed in chapter 4.

Figure 11 illustrates that by 2017/18 potential savings ranging from £240 million to £735 million could be achieved by councils.

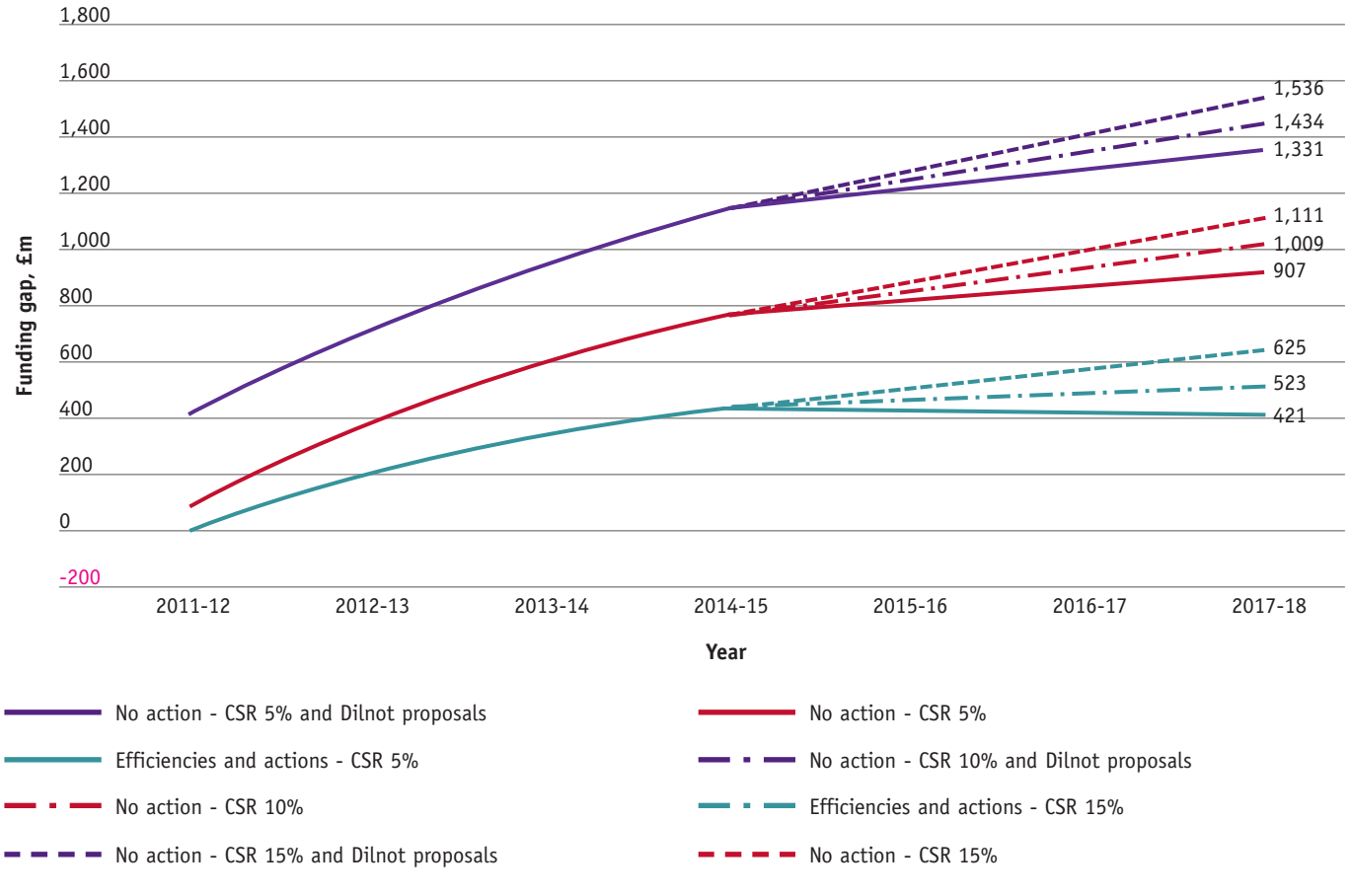
However, for this research we needed to know whether achieving these savings would cover the projected funding gap in adult social care. The financial modelling in this research found that, in the absence of the Dilnot Commission's proposals being implemented, even if councils achieved savings to the projected maximum of £735 million (as illustrated in the graph above), there would still be a funding gap in London that would require the government to increase its funding allocation to London boroughs from current levels.

Figure 12 over illustrates three different scenarios to show what the potential funding gap would be by 2017/18:

- An illustration of the projected funding gap if spending continues on its current trend without boroughs making savings and without implementation of the Dilnot Commission's proposals. It makes the assumption that councils will continue with their current spending projections. As no announcements have been made on what the budget cut will be in the spending review the graph illustrates a potential 5 per cent, 10 per cent and 15 per cent potential budget cut to be announced in the CSR. The worst case scenario (a 15 per cent cut) would potentially see a funding gap in adult social care of £1.1 billion and the best case scenario (with only a 5 per cent CSR cut) would see a funding gap of £907 million.
- An illustration of what the potential impact of councils implementing the four options discussed in this report would be on the funding gap. What is clear in the graph below is that even if local authorities were to achieve maximum savings there would still be a funding gap in adult social care in London ranging between £421 million and £625 million.
- Figure 12 below also illustrates the funding requirements for London if the Dilnot Commission's requirements were to be introduced which would

result in a minimum of £1.3 billion additional funding required in London based on 5 per cent CSR budget cut.

Figure 12: **Understanding the funding gap**



↘06 conclusions and recommendations

The delivery and commissioning of adult social services continues to be a growing challenge for councils particularly within the current economic climate. It is evident that the funding pressures facing adult social care in London are significant and will only intensify over the next few years. Successive governments' failure to find a long-term solution to the question of how to pay for adult care has left local government increasingly struggling to meet the care needs of older adults and adults with disabilities with diminishing resources.

This London Councils project supported by Ernst & Young has sought to explore whether councils could be doing more to enable them to work more efficiently and achieve additional savings from the adult social care budgets.

The report has looked at a number of potential options still open to local authorities to explore in order to achieve savings while maintaining or increasing outcomes for service users. However, it also shows that even if it were possible to exploit the savings from each option to the full, there would still be a funding gap.

It is therefore imperative that government not only supports local government to develop options such as the ones above, but that it also renews its efforts to find a sustainable and fair solution to ensure that there is adequate funding for adult social care over the longer-term.

Responding to increased financial pressures in adult social care

Through the above research, four main options were identified as potentially offering the most opportunities for local authority social care departments to achieve additional savings. Further analysis was then undertaken to identify the current state of development in these areas, any notable case studies, barriers and lessons learnt and the scale of potential savings for London that could be realised.

- Health and social care integration

This requires both the health sector and local government to approach care and health in a holistic way and to change the way that they work to achieve better alignment of services and support. The results would not only achieve significant savings but also a better experience for service users too.

Range of potential savings for London: £125 million – £375 million by 2017/18

- Implementation of alternative delivery models

This option concerns the establishment of Local Authority Trading Companies or social enterprises as an alternative to in-house provision of adult social care services.

Range of potential savings for London: £70 million – £220 million by 2017/18

- Category management

This option involves local authorities moving towards a more systematic and disciplined approach to the procurement of goods or services.

Range of potential savings for London: £45 million – £140 million by 2017/18

- Public Health

This option involves local authorities using their new responsibilities for public health to improve the health of communities and prevent or delay need for both care services and health services. It is too early at this stage to estimate potential savings that could be achieved from increased investment in public health.

What is the potential overall saving from implementation of the above options?

Based on the financial modelling carried out for this research, there is the potential for London local authorities to save between **£240 and £735 million** from implementing integration in health and social care, alternative delivery models and category management, with additional longer-term savings anticipated from increased investment in public health.

However, the ability of councils to achieve these savings is dependent on government policy decisions and also on the extent of demographic pressures. Not all of the four options above will be appropriate for every local authority and the savings attained will vary across London. The projected figures illustrated in this report therefore provide only an indication of what could be achieved.

Recommendations for government

Financial Support

The recommendations put forward by the Dilnot Commission are not a solution to addressing the funding pressures currently being experienced by councils in the delivery and commissioning of adult social care in London. Government needs to make more of a commitment to increasing funding to the sector.

1. In the absence of the Dilnot recommendations being implemented and efficency savings, government needs to increase adult social care budgets to London councils (by a minimum of £907 million) by 2017/18. However, this could potentially rise to £1.1 billion if the next CSR budget cuts are as high as 15 per cent and no savings are made by local authorities. (It is important to note that the impact of the Dilnot Commission's proposals are not included in the calculation of this funding gap).

2. If the Dilnot recommendations were to be implemented and with estimated 15 per cent budgets cuts a minimum of at least £1.5 billion additional funding would be required to enable local authorities in London to meet the proposals put forward by the Dilnot Commission and also meet the funding gap.

Other ways that government can support local authorities

Government should maximise the opportunities for local authorities to pursue the four options for achieving savings identified above by:

3. Driving forwards a change in data protection regulations that will enable adult social services and their health partners to share information more easily regarding service users.

4. Creating policies that enable an increase in multidisciplinary working across both health and adult social care.

5. Removing tariff-based payment models that are activity based with little incentive to reduce activity by acute trusts through investment in integrated community services.

6. Encouraging the NHS and local government to focus on positive outcomes for patients and service users and to move away from focussing on targets and tariffs

7. Looking at how the process for local authorities to implement alternative delivery models could be simplified and made less expensive.

8. Setting funding for public health to local government at appropriate levels to meet local needs. Furthermore government should ensure that the requirements for the funding to be ring-fenced should be as least burdensome as possible and should afford local authorities maximum flexibility in terms of how they are able to use the ring-fenced public health grant to meet local needs, which should the choose may be towards prevention and early intervention so that people stay healthier for longer and out of the care/health system.

What changes are required in how local authorities work to enable to maximise the potential savings they could make?

Local authorities are already exploring different ways of delivering and commissioning adult social care services. In all likelihood, funding pressures over the coming years are likely to worsen and the age profile of the population will continue to get older. Local government needs position itself to meet this challenge and the following are potential ways that local authorities could do this:

1. Local authorities need to be in close discussion and engagement with key partners particularly the NHS. If potential savings from collaboration and integration between health and social care are to be realised, on-going dialogue is essential.

2. Local authorities need to work with the NHS particularly GPs and other key partners to ensure that information is available and shared across the sector. GPs could play a critical role in sign posting to community based services.

3. Local authorities need to begin to explore the benefits in implementing alternative delivery models. To optimise the benefits, local authorities need to consider working with other local authorities possibly sub-regionally (over coming political differences) to enable them to achieve scale and critical mass as this critical to success and the potential savings that can be achieved.

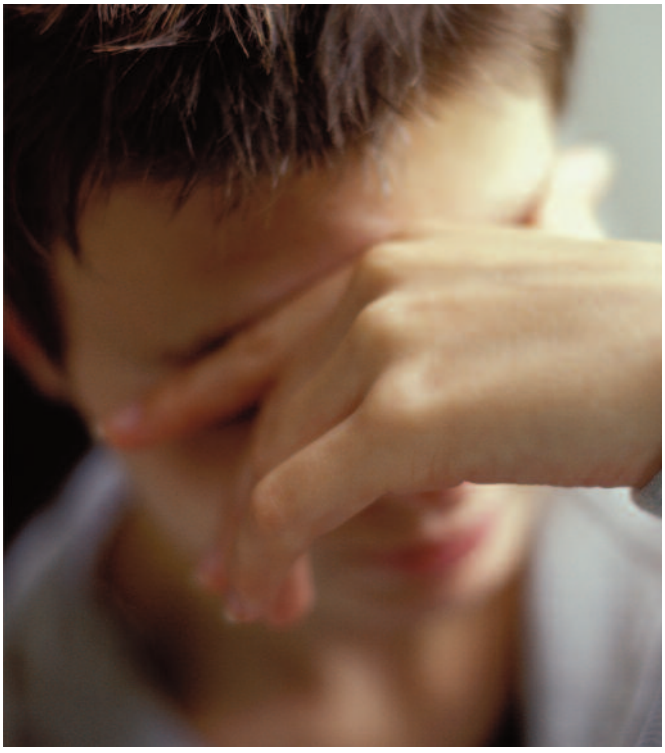
Next steps

London Councils will continue to explore potential opportunities that would enable local authorities to meet the on-going pressures in adult social care. Over the coming year London Councils will specifically seek to engage and offer support to key elected members and Borough Leaders to further explore how councils can effectively address the challenges they face in adult social care.

London Councils is particularly keen to see the results of the Community Budgets pilots as they offer further opportunities to local authorities that could have an impact on adult social care.

London Councils will continue to lobby and work with government and the Department of Health and other key players to ensure that they recognise the pressures on London.

Prior to the comprehensive spending review, London Councils will be working with other key stakeholders in the sector to lobby government for a fair share of funding for London.



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